Nursing Home Litigation: A Brief Review of Claims, Preventing Them, Spotting Them, And A Discussion of Discovery Issues

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In 1999, there were 18,000 nursing homes operating in the United States. The average number of beds per nursing home was 105.

Three quarters of current residents required assistance with 3 or more activities of daily living (ADLs). Most residents received help with bathing (94 percent) and dressing (87 percent). More than half (56 percent) received help using the toilet, and almost half (47 percent) received help with eating.[2]

"Oh yeah, life goes on, long after the thrill of living is gone." [3]

Introduction

The U.S. Population is aging.[4] As it does, the nursing home population will grow, as will the percentage of persons dying in nursing homes.[5] When the elderly require assistance with two

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[2] The National Nursing Home Survey: 1999 Summary, Data Highlights, available at http://www.cdc.gov/nchs/products/pubs/pubd/series/sr13/160-151/sr13_152.htm.

[3] John Cougar Melloncamp, "Jack & Diane".

[4] This year, 6,000 Americans will turn 65 every day. Within ten years, the number will increase to 10,000 per day. Alliance for Aging Research, Medical Never-Never Land: Ten Reasons Why America is Not Ready for the Coming Age Boom (Presented to the Senate Special Committee On Aging, February 2002), available at http://www.agingresearch.org/brochures/nevernever/nevernever.pdf.

[5] In 1999, 1.6 million Americans resided in nursing homes. Of that number, 90% (1.5 million) were aged 65 or older. The National Nursing Home Survey: 1999 Summary, page 2 (DHHS June 2002), available http://www.cdc.gov/nchs/data/series/sr_13/sr13_152.pdf. "Projections for the future predict that two out of every five persons who turned 65 in 1990 will enter a nursing home at some time before they die. One in four will spend at least a year of their lives in a nursing home, and one in 11 will spend 5 or more years." Mayo Clinic Rochester, The

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or more activities of daily living,[6] their independence may be in jeopardy and the burden on informal care givers may be so great that help must be found.[7] In theory, nursing homes serve society by providing appropriate care for persons who have chronic illnesses.[8] In truth, nursing homes often fail miserably and in many cases place nursing home residents at risk of serious injury.[9]

The admission to the nursing home and meritorious nursing home litigation "bookend" a

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Medical Care of Nursing Home Residents, at http://www.mayo.edu/geriatrics-rst/NH.RTF.html#RTFToC3. For other statistics on the growth of the nursing home population, see resources cited in T. Takacs & D. McGuffey, Medicaid Planning: Can It Be Justified: Legal and Ethical Implications of Medicaid Planning, 29 William Mitchell L.R., 111 (2002). In 1989, 8.5% of Georgians died in a nursing home (compared with 17.3% nationally). By 1997, that percentage increased to 19.3% (compared with 24.1% nationally). Georgia State Profile, Facts on Dying 2002 (Brown University), at http://as800.chcr.brown.edu/dying/gaprofile.htm.

[6] Bathing, dressing, grooming, transfer and ambulation, toileting, eating, and use of speech, language or other functional communications systems. 42 C.F.R. § 483.25(a)(1). See also Mayo Clinic Rochester, ADLs: Activities of Daily Living, at http://www.mayo.edu/geriatrics-rst/ADLs.html.

[7] Risk factors for nursing home placement include living alone, loss of ability for self care, impaired mental status, lack of social or informal supports, poverty, and female sex. The Merck Manual of Geriatrics, Third Edition 106, 108 (Merck 2000); Joan Winryb, Nursing Homes, in Geriatric Secrets, Second Edition, pp. 324-331 (Hanley & Belfus, Inc. 2000). As for caregivers, surveys sometimes paint a portrait of a society that reaches out to those in need. See K. Donelan et al., Challenged to Care: Informal Caregivers in a Changing Health System, 21 Health Affairs 222, 229 (July/August 2002). Still, caring for disabled or chronically ill loved ones is a difficult prospect and can place an enormous emotional and financial burden on care givers. Id. And see other sources cited in T. Takacs & D. McGuffey, supra, 144-146 (2002). At some point, care givers are simply at the end of their ability and often, at the end of their rope. For more on caregivers, see Family Caregiver Alliance (http://www.caregiver.org/) and National Alliance for Caregiving (http://www.caregiving.org).

[8] "[T]he primary business purpose of a nursing home is to take care of residents who, because of age, infirmity or some ailment, are no longer able to take care of themselves." Pye v.Taylor & Bird, Inc., 216 Ga. App. 815, 815 (1995). "The care of aged persons in our society is a matter of great public concern. Many of our elderly require some, if not constant, care or supervision. And where members of their family are unable to provide such attention, nursing home care sometimes is the only reasonable alternative." Associated Health Systems, Inc. v. Jones, 185 Ga. App. 798, 800 (1988).

[9] "Almost one out of every three U.S. nursing homes were cited for an abuse violation in the two-year period from January 1, 1999, through January 1, 2001. All of these violations had at least the potential to harm nursing home residents. In over 1,600 of these nursing homes, the abuse violations were serious enough to cause actual harm to the residents or to place the residents in immediate jeopardy of death or serious injury." Minority Staff, Special investigations Division, Committee on Government Reform, U.S. House of Representatives, Abuse of Residents Is a Major Problem in U.S. Nursing Homes (July 30, 2001). Available on the internet.

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nursing home tragedy. As elder law attorneys, we are uniquely positioned to counsel elders and care givers as they approach the point where help is required. By doing so, we can help prevent nursing home tragedies.[10] We help prevent nursing home tragedies when we empower elders and care givers to shape their future with information concerning resident rights, danger signs and securing appropriate care.[11] We should use every opportunity at our disposal to prevent injuries, and hence to prevent nursing home litigation.[12]

Why do nursing home tragedies occur? In part, they occur because nursing home residents are dehumanized.[13] The wants, needs and rights of residents, which are identical to those possessed by all other citizens, may be ignored.[14] Too often, we forget this rather obvious fact. I say "we" because the nursing home industry is not the only sector guilty of forgetting that nursing home residents are people. As (Plaintiff's or "contingent fee") lawyers, we sometimes view the nursing home resident as a "case" or a "fee"; that view is inappropriate. When someone calls my office to discuss a nursing home case, it generally means that a living, breathing and

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[10] "The work done by the elder law bar is designed to help others." J. Braun & E. Capezuti, Nursing Home Litigation and the Elder Law Attorney, 14 NEALA Quarterly 3 (2001) (quoting Thomas D. Begley, Jr. & Jo-Anne Herina Jeffreys)

[11] Id.

[12] When we prevent injury, we prevent litigation. Some loss or damage flowing from a legally protected interest is an essential element to a tort claim. E.g., Heston v. Lilly, 248 Ga. App. 856, 857-858 (2001). "The law of torts imposes legal liability on persons who in certain ways have caused certain kinds of harm to others. ... Damages is a backward-looking remedy that is intended to compensate the plaintiff for harm suffered." Stephen R. Perry, Tort Law, in A Companion to Philosophy of Law and Legal Theory, at 57(Blackwell Publishers 1996, 1999).

[13] "This country has come to rely upon a failed system of warehousing the elderly as the primary—and for many families, the only—long -term care option." Ken Connor, Warehousing the Elderly, available at http://www.frc.org/get/ar01j2.cfm (article originally published in the Tampa Tribune September 2, 2001).

[14] 42 C.F.R. § 483.10(a)(1); O.C.G.A. § 31-8-111.

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loved human being was harmed. Often, the harm occurred because the long-term care industry and government (and sometimes families) dehumanize nursing home residents, placing profit before people.[15] When nursing home residents are dehumanized – when they become mere objects – the quality of care invariably declines.[16]

Therefore, because elder advocates *should* work to improve lives, a primary purpose for this paper is to provide a resource that can be used to prevent tragedy. When nursing home residents are harmed, we must use available resources to prevent a reoccurrence. In part, this means reorienting wrong-doers by demonstrating that their conduct is unacceptable and that consequences follow wrong-doing. We must insist on accountability or justice. When we demand accountability, by necessity we demand change. When we demand change, we become part of the solution to the current nursing home care crisis. When we fail to demand change, we telegraph the message that the status quo is acceptable. As Elder Advocates, we must decide which message we will send.

Preventing Problems Before They Happen

Obviously, the best result is to prevent problems before they arise. This can be done in a

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[15] For example, a Special Report in U.S. News & World Report describes the situation at the Shields Nursing Home (El Cerrito, California) as follows: "[W]hile the patients endure daily indignities and even unsafe conditions, the home's operator, William Shields, has reaped millions to furnish an affluent lifestyle that has included a small fleet of luxury cars, a million dollar mini-mansion, and trips to Hawaii and Lake Tahoe." C. Schmitt, Home $weet Home, U.S. News & World Report, p.70 (September 30, 2002). Other sections of the report state that nursing homes are reaping huge profits siphoning funds off for "management fees" leaving little for resident care. At least one home spends less per day feeding its residents than the State spends feeding prison inmates.

[16] If the value of human life is inferior to other goals, such as long term care industry profit margins, then otherwise unacceptable behavior becomes acceptable. Nazi Germany justified the Final Solution because "The Jews and the Slavic peoples were *Untermenschen* – subhumans." W. Shirer, The Rise and Fall of the Third Reich 1223 (Fawcett Crest 1950, 1992).

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number of ways. The process begins by taking time to select (or by trying to select) a quality nursing home.

Advice For Clients Selecting and Dealing with Nursing Homes:

Make certain that your clients understand the importance of making a personal visit to each nursing home being considered. They should visit each facility more than once, preferably unannounced and during different shifts. As they go, they should use their common sense, as well as their senses (sight, hearing, etc.) and should take notes. Many useful checklists are on the internet and they should use one or more of them as they visit. Among them is the Nursing Home Checklist, available at http://www.medicare.gov/Nursing/Checklist.pdf, on the Centers for Medicare & Medicaid Services website. Among issues they should consider are the following:

Questions to Ask When Evaluating a Nursing Home:

1. **Is the facility Medicare Certified?**[17]
2. **Is the facility Medicaid Certified?**[18]
3. Is the nursing home's operating license current?[19]
4. Is the nursing home administrator's license current?[20]

5. Has the nursing home corrected all deficiencies cited during the most recent survey (ask for a copy of the survey report)?[21]

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[17] Certification may impact how the nursing home stay is financed. A Medicare certified facility must comply with 42 USC § 1395i-3, and with 42 CFR Part 483. In Georgia, the facility's certification status is at http://www2.state.ga.us/Departments/DHR/ORS/.

[18] Certification may impact how the nursing home stay is financed. A Medicaid certified facility must comply with 42 USC § 1396r, and with 42 CFR Part 483. In Georgia, the facility's certification status is at http://www2.state.ga.us/Departments/DHR/ORS/.

[19] 42 CFR 483.75(a)

[20] 42 CFR 483.75(d)(2)(i). In Georgia, a nursing home administrator's license can be verified at: https://secure.sos.state.ga.us/myverification/.

[21] Statement of Deficiencies and Plan of Correction, HCFA Form 2567.

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6. What is the Home's reputation in the Community? (Contact local consumer groups and check 'Nursing Home Compare" at www.medicare.gov).

7. Who owns the nursing home?[22]
8. How long has it been in business?
9. Who operates the nursing home (e.g., management company)?
10. Ask for a financial statement.
11. Does the nursing home have a written policy covering abuse and neglect?[23]
12. Does the facility subscribe to and can it provide you with a copy of a resident's bills of rights?[24]

13. Physician, Hospital and Other Health Services:

    a. May residents select their own physicians?[25]
    b. May residents select their own hospital?
    c. Are arrangements made for residents who wish to use alternative professional services such as chiropractors or podiatrists?
    d. Is a physician on the premises for a fixed time each day?
    e. Is a physician on call 24 hours each day?[26]
    f. Are there places outside of the resident's rooms for physical examinations?
    g. Does the facility have a contract with an ambulance service?

14. Nursing Services:[27]

    a. Is a registered nurse on duty during the day 7 days a week?
    b. Is at least 1 registered nurse and 1 licensed practical nurse on duty at all times?
    c. Does the same team of CNA's work with the same resident four to five days per week?

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[22] In Georgia, this information is on file with the Office of Regulatory Services and can be secured with an open records request. Georgia still used HCFA Form 1513, Disclosure of Ownership and Control Interest Statement.

[23] 483.10(a)

[24] 483.10(b)(1); (b)(7)

[25] O.C.G.A. § 31-8-108(b)(1)

[26] 42 CFR 483.40(d)

[27] Georgia nursing regulations are at: http://www.ganet.org/rules/index.cgi?base=410.

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d. Does the facility make arrangements for private duty nurses when the facility thinks one is required?

15. Are dental services provided in the home itself?[28]

16. Pharmacy Services[29]:

    a. Does the facility have access to 1 pharmacist who maintains records on each resident and reviews them when new medications are ordered?[30]
    b. Is a separate room set aside for storing and preparing drugs?[31]

17. Does the facility keep its own medical records?
18. Do residents and their families have free access to their own medical records?[32]

19. Are the staff open to your questions?

    a. If possible, speak with the Administrator;
    b. The Director of Nursing; and
    c. The Social Services Director.
    d. Try to talk with more than one nurses aide.
    e. How interested is the staff in learning about your loved one (e.g., are they taking notes)?

20. Evaluate the Staff:

    a. Are the staff generally friendly toward you?
    b. Do the staff seem to like the residents?
    c. Do the staff generally look pleasant and cheerful?
    d. Do the staff wear name tags?
    e. Does the facility employ full time social or activities director?

21. Review the admission agreement (if you have questions, consult an attorney).

    a. What does the nursing home agree to do?

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[28] 42CFR 483.55

[29] 42 CFR 483.60

[30] 42 CFR 483.60(c)

[31] 42 CFR 483(e)

[32] 42 CFR § 483.10(b)(2).

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b. What are the charges?
c. What services are covered by Medicare/Medicaid and what triggers an additional charge?
d. When must payments be made?
e. What happens when the resident runs out of money?
f. Are trial periods permitted?
g. What notice is required if the resident decides to leave?
h. What is the discharge policy?

22. Is the nursing home environment pleasant?

a. Are the rooms and halls free of unpleasant odors?
b. Do the rooms smell of heavy perfume?
c. Is the temperature comfortable?
d. Are the rooms well ventilated?
e. Is the nursing home noisy?
f. Are hallways and other areas cluttered?

23. Are individual rooms and facilities structured for safety, privacy and appeal?

a. Are rooms clean and neat?
b. Is there sufficient closet space?
c. Does each resident have a sink and mirror?
d. Are the rooms nicely furnished?
e. Does each resident have a call button within easy reach of his or her bed?
f. Are the bathrooms and bath areas equipped with call buttons?
g. Does each resident have a water container and clean glass in the room?
h. Do bathrooms have safety bars?
i. Do tubs have non-slip surfaces?
j. Does the resident have enough personal space?
k. Do the rooms afford privacy?
l. Do the rooms have windows?
m. Is there counter space for personal objects?
n. Does the room have an individual thermostat?
o. Is there an adjoining bathroom?
p. How many residents share the bathroom?
q. Can residents hang their own pictures and place their own furniture?
r. Do residents have a place to lock valuables?
s. Do the linens look clean?
t. Do staff members knock on doors prior to entering patient rooms?

24. How is the food and food service?

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a. Eat a meal in the facility while you are visiting.
b. Does the kitchen appear to be clean by your standards?
c. Is the dining room clean?
d. Can the kitchen accommodate special diet needs?
e. Is help available for residents who need assistance eating?
f. Is a dietician on staff?
g. Do dirty dishes stay out long after meals are served?
h. Are residents with special needs given assistance eating?
i. Are there menus?

25. Do the residents appear to be happy and well cared for?

a. Are residents smiling?
b. Are there more inactive residents properly groomed?
c. Spend time sitting in different parts of the facility watching how staff interact with residents.
d. Look for signs that resident interaction is encouraged.
e. Observe one or more planned activity sessions.
f. Are patients treated with dignity and respect?
g. Are call lights sounding for a long time before being answered?
h. Are patients calling for help for a prolonged time?
i. Do the residents smell clean?
j. Are barbers and beauticians available?
k. Are the residents included in the planning of recreational events?
l. Is there an actively functioning resident council?
m. Is there an actively functioning family council?[33]
n. Is there sufficient room for residents to engage in social activities?
o. Are calendars of events posted?

    i. Movies?
    ii. Crafts?
    iii. Low impact aerobics?
    iv. Social events?
    v. Outings?

p. Are religious services held on the premises?
q. Is there a formal health education program for residents?
r. Does the facility have policies that limit the use of physical restrains?
s. Are the majority of residents free of physical restraints?
t. Can residents get up and go to bed at a time of their choosing?

[33] If possible, clients should attend a family council meeting.

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u. Are books, magazines and newspapers available?
v. Is the staff cross-culturally trained?
w. If the resident does not speak English, is there a staff member who speaks the resident's language?
x. What are the visitation hours and policies?
y. Can visitors (family members) stay overnight?
z. Can visitors dine with the residents?

26. Is the facility itself structured for safety and appeal?

a. Does the building appear to have fire safety devices?
b. Is the furniture both study and comfortable?
c. Are sidewalks clean and well maintained?
d. Are the emergency exits well marked?
e. Are there sufficient smoke detectors?
f. Is there a safety committee?
g. Do the sidewalks have wheelchair ramps?
h. Is the home within easy walking distance of public transportation?
i. Does the surrounding neighborhood appear safe?
j. Is there an area where residents can sit outside?
k. Is there sufficient light?
l. Do residents appear to sit and walk outside, weather permitting?
m. Is the facility air conditioned?
n. Are private telephones allowed and/or provided?
o. Are there any strong odors in the facility?

Ask Other Residents and Family Members:

1. What's the best thing about this nursing home?
2. What is the worst thing about this nursing home?
3. Are you happy here?
4. Is the staff helpful and caring?
5. Does the staff meet your needs?
6. Have you ever complained about anything here?
7. What happens when you express a complaint or concern?
8. Do you attend resident/family counsel meetings?
9. Were you involved in choosing your room and/or roommate?
10. Is the food good and do you get enough to eat?
11. Have you ever possessions turn up missing?
12. Does each shift have enough help?
13. How does the staff treat you?
14. How often do the staff check on you when you are in your room?
15. Does the staff provide needed assistance with toileting, bathing, dressing and

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eating?

16. Do you attend and enjoy the activities provided in the nursing home?
17. Are you invited to care plan meetings?
18. Does the staff close the door and pull the privacy curtains when they provide care?

You should also advise clients to look for signs of elder abuse or neglect. Again, there are many resources on the internet to assist clients in understanding and identifying abuse and neglect. Among signs and symptoms are the following:

Signs and Symptoms/Physical Abuse:

1. Bruises, black eyes, welts, lacerations, and rope marks;
2. Bone fractures, skull fractures;
3. Open wounds, cuts, punctures, untreated injuries in various stages of healing;
4. Sprains, dislocations, internal injuries/bleeding;
5. Broken eyeglasses/frames, physical signs of being subjected to punishment and signs of being restrained;
6. Laboratory findings of medication overdose or under utilization of prescription drugs;
7. Reports of being hit, slapped, kicked, or mistreated;
8. Sudden changes in behavior and the caregiver's refusal to allow visitors to see an elder alone.

Signs and Symptoms/Sexual Abuse:

1. Bruises around the breasts or genital area;
2. Unexplained venereal disease or genital infections;
3. Unexplained vaginal or anal bleeding;
4. Torn, stained or bloody underclothing; and
5. Reports of being sexually assaulted or raped.

Signs and Symptoms/Psychological Abuse:

1. Being emotionally upset or agitated;
2. Being extremely withdrawn or non-communicative or non-responsive;
3. Unusual behavior usually attributed to dementia; and
4. Reports of being verbally or emotionally mistreated.

Signs and Symptoms/Neglect:

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1. Dehydration, malnutrition, untreated bed sores, and poor personal hygiene;
2. Unattended or untreated health problems;
3. Hazardous or unsafe living conditions or arrangements;
4. Unsanitary and unclean living conditions (dirt, fleas, lice, soiled bedding, Fecal/urine smell, inadequate clothing); and
5. Reports of being mistreated.

Signs and Symptoms/Abandonment:

1. Desertion of an elder at a hospital, nursing facility or similar institution;
2. Desertion of an elder at a shopping center or public location;
3. Reports of being abandoned.

After identifying the best nursing home available, review the admissions paper work. Advice clients to participate in the admissions process for the purpose of ensuring that the nursing home "knows" the resident, including his/her daily routine, food preferences and other likes and dislikes. Attorney participation in the initial care plan meetings can ensure that an appropriate care plan is drawn. Follow the resident's treatment program, checking it from time to time to ensure that the care plan is followed. Over time, if problems arise, be prepared to assist the family through the grievance process to ensure that problems are noted and addressed.[34] If they are not, especially where abuse or neglect occurs, then it may be appropriate to consider litigation.

What Care is Required?

> *Decisions concerning whether the nursing home is liable for a bad outcome often turn on "whether there was a lack of appropriate care that contributed to the event, directly or indirectly, or whether the outcome was an unpreventable consequence of the natural progression of advanced and complex medical*

[34] 42 CFR § 483.10(f); O.C.G.A. § 31-8-124.

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conditions." [35]

Nursing home[36] care should be measured against a standard that is neither impossible to determine, nor impossible to achieve. Simply stated, nursing homes must deliver adequate and appropriate quality care, which means "doing the right thing, at the right time, in the right way for the right person."[37] Federal regulations require that nursing homes provide that level of care and those services necessary to attain or maintain each resident's highest practicable physical, mental and psycho-social well-being.[38] The nursing home must individually assess[39] the needs of nursing home residents and develop a comprehensive care plan that includes measurable

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[35] S. Castle & J. Braun, Use of Experts in Nursing Home Litigation: Perspective of the Medical Expert in The Trial Attorney's Advanced Guide to Trying and Defending Nursing Home Litigation. (ACI June 20 & 21, 2002)

[36] "A *Nursing Home* is a facility which admits patients on medical referral only and for whom arrangements have been made for continuous medical supervision; it maintains services and facilities for skilled nursing care, rehabilitative nursing care, and has a satisfactory agreement with a physician and a dentist who will be available for any medical and/or dental emergency and who will be responsible for the general medical and dental supervision of the home; it otherwise complies with these rules and regulations." Ga. Regs. § 290-5-8-01(a). See also 42 U.S.C. § 1396r(a) (defining "nursing facility").

[37] CMS, Guide to Choosing a Nursing Home, at 16 (Publication Number CMS-02174 April 2002). "Each resident shall receive care, treatment and services which are adequate and appropriate. Care, treatment and services shall be provided ... with reasonable care and skill and in compliance with applicable laws and regulations." O.C.G.A. § 31-8-108(a).

[38] 42 C.F.R. § 483.25. "A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident." 42 U.S.C. § 1396r(b)(1)(A). In Georgia, Statutory and regulatory authority goes further: "Each resident must receive care, treatment and services which are adequate and appropriate for the condition of the resident, as determined by periodic review of each resident's treatment plan. Such care, treatment, and services must be provided with reasonable care and skill and in compliance with all applicable laws and regulations and with the goal of the resident's return home or to a less restrictive environment. Ga. Reg. § 290-5-39-.07. " See also 42 U.S.C. § 1396r(b)(4)(A); O.C.G.A. § 31-8-108.

[39] 42 C.F.R. 483.20(b)(1). Assessment is a continuing process. The facility must make a comprehensive assessment of a resident's needs within 14 days following admission, 42 C.F.R. § 483.20(b)(2)(i), and must re-assess the resident within 14 days after any significant change in condition. 42 C.F.R. § 483.20(b)(2)(ii). Quarterly and annual assessments are required regardless of any change in condition, 42 C.F.R. 483.20(b)(2)(iii) & (c). The facility must use their assessments in developing, reviewing and revising the resident's comprehensive plan of care. 42 C.F.R. § 483.20(d).

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objectives and timetables to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the assessment.[40] That plan must then be properly implemented. Negligence often occurs when a resident is improperly assessed, when the care plan is never developed or is ignored, or when there is no intervention following a change in the resident's condition.[41]

Initial Meeting & Review of Claim

When the "client" arrives in your office, generally he/she feels like the nursing home injured or killed Mom (or Dad). They want someone to listen to their story. Do it. Take good notes.

A typical nursing home consult might be as follows:

> *My mother's health was declining and she went into the hospital. The doctor told us that we could not take care of her anymore because she needed twenty four hour care. We looked at several nursing homes, but settled on nursing home X because it looked nice and was close to our home. After she was admitted, the nursing staff started making Mom wear diapers even though she could use the bathroom. They would not help her get out of the bed and, pretty soon, she stopped getting out of bed. The food was horrible and she started losing weight. Then one day, we discovered that she had this huge sore on her bottom, ...*

The initial meeting is your first, best chance to hear about the emotional ordeal the nursing home resident and family have experienced. By listening, you also let the family know

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[40] 42 C.F.R. 483.20(k)(1). A comprehensive interdisciplinary care plan must be developed within 7 days after completion of the comprehensive assessment. 42 C.F.R. § 483.20(k)(2)(i). It must be periodically reviewed and revised after each assessment. 42 C.F.R. § 483.20(k)(2)(iii). Services must meet professional standards of quality and must be provided qualified persons in accordance with the plan of care. 42 C.F.R. § 483.20(k)(3).

[41] Improper assessment would be akin to a failure to diagnose claim. Regarding mis-diagnosis, see C. Royal & T. Alexander, Handbook on Georgia Medical Malpractice Law § 2-2 (Harrison 1991).

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– for perhaps the first time in a long time – that someone cares. Ask questions that will help you know where to look as you start turning over rocks:[42]

- Was "Mom" allowed to sit or lay in her own urine or excrement for extended periods of time;
- Were requests for care (e.g., call light requests) ignored;
- Did "Mom" develop pressure ulcers;
- Were there missed treatments, therapies, and medications;
- Were there missed meals or an absence of fluids;
- Did "Mom" experience unexplained weight loss;
- Were restraints used improperly;
- Was there physical or verbal abuse.

As you listen, your first job is to evaluate the claim,[43] the prospective client and to separate the wheat from the chaff. When you evaluate the claim, keep in mind that nursing home

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[42] In sum, what is it that the family is complaining about?

[43] "Evaluating the nursing home abuse and neglect case begins with the proposition that the criteria traditionally used to assess the potential recovery in a personal injury case are simply not applicable to injury arising out of neglect and injury of a long term care resident." J. Rothkoff, Litigating Nursing Home Abuse and Neglect Cases, 214 New Jersey Lawyer 12 (April 2002). Traditionally, damages are evaluated in terms of lost wages, lost earning potential and future health care expenses. Id. Also keep in mind that in Georgia, a nursing home claim is an action for medical malpractice. O.C.G.A. § 9-3-70, which generally defines those actions to include any claim for damages resulting from the death or injury to any person arising out of care rendered by a health care professional authorized by law to provide such services, or any person acting under that person's direction, or care provided by an institution such as a nursing home. Thus, special rules applicable to tolling of medical malpractice cases, and the statute of repose will apply. See O.C.G.A. § 9-3-33 (two year statute of limitations on actions to personal injury); O.C.G.A. § 9-3-71 (statute of repose, generally 5 years); O.C.G.A. § 9-3-73 (tolling); and O.C.G.A. § 9-3-97.1 (tolling of medical malpractice cases). Another section often applicable in nursing home cases is O.C.G.A. § 9-3-92, which tolls the statute of limitations up to five years for unrepresented estates. See also Moore v. Louis Smith Memorial Hospital, Inc., 216 Ga. App. 299 (1995), where the Court rejected the notion that all claims against health care facilities are malpractice claims and held that a claim for ordinary negligence (the resident was injured while being moved from a wheel chair) was tolled due to incapacity.

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litigation is very different from traditional personal injury or "single-event" injury litigation. First, nursing home injuries often stem from neglect over time.[44] Second, the measure of damages is very different.[45]

As an initial proposition, a litigator should not accept any case that he/she would not submit to a jury. Thus, it may be advisable to accept cases with the proviso that you will investigate the claim and make a final decision afterward.[46] You should consider drafting your fee agreement so that representation may be terminated following investigation if you determine that the claim is not viable, either on legal or economic grounds.[47] If, after investigation, you intend to associate litigation counsel, that should be discussed up front.[48]

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[44] "Often you will find that a mediocre facility provides adequate treatment when the patient is self sufficient but fails the more limited the patient becomes." D. Green, Preparing the Nursing Home Malpractice Case, presented at Preparing the Nursing Home Malpractice Case (GTLA September 11, 1998).

[45] R. Krisztal, Nursing Home Litigation: Discovery, in Mealey's Nursing Home Litigation Conference 2002 (Lexis-Nexis 2002). This does not, however, mean that nursing home claims result in small verdicts when prepared properly. In Georgia, for example, although it may include the insurer's defense costs, the average policy claim was $261,000 in 2001. See T. Bourdon & S. Dubin, Long Term Care: General Liability and Professional Liability 26 (AON Risk Consultants February 28, 2002).

[46] See Comment 1, Tennessee Rules of Professional Conduct, Rule 1.16, and Georgia Rules of Professional Conduct 1.16 ("A lawyer should not accept representation in a matter unless it can be performed competently, promptly, without improper conflict of interest, and to completion") (emphasis added). Thus, it may be advisable to limit the scope of representation, see Rule 1.2(c), to permit evaluation before agreeing to take the case "all the way." At least one well respected lawyer disagrees, stating that, in his experience, it is better to sign the client up, and let them know later if the case is not viable. Ultimately, this may be a judgment call.

[47] Before filing suit, you should always determine as best you can whether your client's claim is likely to survive summary judgment, meaning, you must have "Grounds for a lawsuit." See S. Hemp, The Right to a Remedy: When Should An Abused Nursing Home Resident Sue?, 2 Elder Law Journal 195, 206 (1994) (e.g., duty, breach, causation and damages). Without these elements, the claim is not legally viable. You should also recognize that nursing home litigation is expensive. It is not uncommon to advance expenses of $50,000 to $100,000 preparing a case for trial. Thus, if your evaluation of the damages suggests that the case would produce a verdict of less than the cost of preparation, it is not economically viable.

[48] See, e.g., Georgia Rules of Professional Conduct, Rule 1.5(e); and Tennessee Rules of Professional Conduct, Rule 1.5(e). ATLA's Nursing Home Litigation Group is an excellent place to find litigation counsel.

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As part of your investigation, you must evaluate the credibility and appearance of your client. Does the client either make a good appearance or, if necessary, can you clean up the client's appearance?[49] What was the client's relationship to the resident? Did the client have a quality relationship with the nursing home resident?[50] Did the client visit the resident? How often were they present and what did they witness? Did other family members visit the resident and, if so, who are they and what did they witness? Can they identify other witnesses, staff members and former staff members?[51] Obviously, a family member who visited often is more likely to convince a jury that a valuable relationship was damaged and is better able to assist you in identifying inadequate care.

What was the client's relationship with the nursing home? Were complaints filed and, if not, why not? If complaints were filed, did the nursing home also document hostility on the part of the client? If so, can that hostility be explained?

Is the resident still in the nursing home and, if so, do you plan to relocate the resident? If not, why not? The classic nursing home response is: "If the care here is that bad, then why

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[49] Are you dealing with Ward and June Cleaver or with the Manson family? See J. Olsman, Screening and Investigating the Nursing Home Case, presentation at Nursing Home Neglect and Abuse Claims Part I (Tennessee Trial Lawyers Association, August 30 & 31, 2002). Also consider whether your prospective client will work with you as you prepare them for the litigation process.

[50] Think very carefully before accepting a care where the family "dumped" Mom or Dad off at the nursing home and then never came to visit. "If a resident's family members, rather than the resident himself, are the principal litigants, it is important that the family members have had a demonstrably close relationship with the resident. Evidence of such a close relationship – for example, a record of frequent visits to the facility – will be necessary to counteract the facilities insinuations at trial that the family members are litigating solely for their own financial benefit." E. Carlson, Litigating Against Long Term Care Facilities, in Long Term Care Advocacy, 10.03[3] (Lexis-Nexis 1999, 2002).

[51] You cannot over estimate the importance of speaking with former staff members. Typically they were over worked and underpaid. After they are off the payroll, they will usually speak more freely about what reeeeeeeeeeally went on at the nursing home.

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haven't you left?" This question is designed to place the family on the defense. Keep in mind that family members often feel helpless. Whatever their answer is, it is often the best answer the family has. Do not allow the nursing home to play games with them on this issue.

> *In the Brogdon litigation, a number of the residents remained at the nursing home when the case was filed. In each instance, family were asked why they didn't simply move the resident. Answers ranged from (i) we like the home, we just want them to provide quality care, (ii) it is the only nursing home close enough for me to visit; to (iii) there isn't anywhere else to go.*

Did the client preserve evidence? For example, if the complaint centers on pressure ulcers, were photographs taken? If the client is complaining that sheets were not changed and the resident was laying in urine and feces, does the client have photographs or other objective evidence that will take the claim beyond a "he said/she said" argument?

Although nursing home negligence claims differ from medical malpractice claims, they remain centered on medical/nursing facts. Thus, it is imperative that you secure a copy of the nursing home chart.[52] We typically provide the client with a copy of 42 C.F.R. § 483.10(b)(i) and instructions concerning how to demand a copy of the record. If the client is unable to secure the record, we request it on our letterhead. A brief example of a letter is as follows:

> *Dear Sir/Madam:*
>
> *This law firm has been retained to represent _____ in connection with _____. As part of our investigation, we are requesting that you make the entire nursing home record relating to _____ available and that you provide us with a complete copy of all records regarding _____. We have enclosed an authorization signed by _____.*
>
> *As you know, Federal law requires that you produce these records for*

[52] Get a color copy of the chart. Often a color copy will show whiteouts or other alterations.

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inspection within twenty-four (24) hours and that you provide copies of these records within two working days of this request. Specifically, 42 CFR § 483.10(b)(2) provides [omitted].

Please make your entire chart available for inspection on _____. I will be at your facility to inspect it on _____ and would like to pick up a complete copy on _____.[53]

You must evaluate the underlying illness that made nursing home care necessary and separate those conditions from the alleged abuse.[54] Failure to do so provides the nursing home with its principal defense: causation.[55] Failure to account for a pre-existing condition will confuse the mechanics of injury and prevent you from clearly explaining to a jury how the nursing home hurt your client. Regardless of the applicable legal standard, you are looking for cases where your expert can testify that if the nursing home provided the proper care, *within a reasonable degree of medical (or nursing) certainty*, the injury would not have occurred.[56]

In Georgia, a nursing home claim cannot be filed without an expert affidavit setting forth at least one act of negligence and the factual basis for that claim.[57] Customarily, we consult with

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[53] The nursing home violates OBRA if it fails to make the record available on this timetable. At least one experienced nursing home lawyer routinely reports the nursing home to State authorities if the nursing home fails to comply.

[54] Hemp, Right to a Remedy, supra, at 213.

[55] Causation is a two-step tango: (i) was there factual cause; and (ii) is there proximate cause. Factual cause is the place where nursing home cases are often bogged down due to the resident's pre-existing medical condition. "Would [the resident] have not been harmed "but for" the defendant's tortious conduct? If the answer to this question is 'yes' – [the resident] would not have been harmed – his tortious act is the factual cause. However, if the answer is 'no,' and the harm would have happened to [the resident] with or without the defendant's conduct, he is not a factual cause of [the resident's] harm." D. Maleski, Proof of Causation in Private Tort Actions in Georgia § 2-1 (Harrison Company Publishers 1986).

[56] For example, be wary of pressure ulcer cases where the resident had peripheral vascular disease.

[57] O.C.G.A. § 9-11-9.1(a). Tennessee does not require an affidavit prior to filing, but defense counsel will typically force the issue by filing a motion for summary judgment, signed by the health care provider alleging that the treatment provided met the standard of care. See E. Hertz et al., Georgia Law of Torts: Forms § 5-

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experts in all cases prior to filing, even where an affidavit is not required and secure an opinion regarding causation as well. This protects us from frivolous litigation claims and provides the client with sufficient information to evaluate the costs and benefits of going forward with the litigation.

Developing a Theory of the Case (Your Client's Story)

> ***"What happens now?" asked Rowse.***
>
> ***McCready stared at the sea and the sky and sighed. "Now, Tom, the lawyers take over. The lawyers always take over, reducing all of life and death, passion, greed, courage, lust, and glory to the dessicated vernacular of their trade."*** [58]

The public distrusts lawyers. Some think we are dishonest. As often, however, the public believes we are mindlessly ruining society through our use of technical rules, in pursuit of attorney' fees. They believe that lawyers, like some mad train engineer, are driving society toward a certain train-wreck. In January, 2003, President Bush voiced this concern, laying the blame for the Nation's "Malpractice Insurance Crisis" squarely at the feet of trial lawyers. Bush called for limits on damage awards in malpractice cases, stating that "frivolous lawsuits were the source of the problem."[59] We must acknowledge this misperception and respond to it appropriately. If we fail to do so, by making a case for accountability, then public attitudes like those expressed in McCready's statement to Rowse in The Deceiver, as well President's Bush's

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1.1 (Thomson-West 2002) for an example of an expert witness affidavit.

[58] F. Forsyth, The Deceiver, at 350 (Bantam Books, paperback, 1995) (McCready's lament follows Frederick Forsyth's brilliant tale describing how "The Deceiver" shut down a Libyan led effort to deliver arms to the IRA and other terrorist groups).

[59] R. Oppel, Bush Urges Nationwide Limits on Medical-Malpractice Awards, New York Times (January 16, 2003) (available on the Internet at www.nytimes.com).

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rhetoric (and that of the lobbyists behind limits on damages), will carry the day. In responding, we must arm ourselves with the truth, avoid frivolous cases, and vigorously press accountability when nursing homes fail to care for the elderly. We must learn to tell our clients' respective stories so that the public understands we seek damages as compensation for injuries suffered, rather than as a windfall. Accountability must remain the central issue in every case.

As trial lawyers, we represent our clients in the court room. The initial proposition is that every litigated claim may make its way to a jury and should be prepared accordingly. There, the trial lawyer weaves a story of human drama, wooing the jury ever closer, bringing the nursing home resident's past back to life. The courtroom is the lawyer's stage. There lies:

> "an audience thirsting to drink deeply of the passing show. Those playing the parts vie for success and use whatever skill and talent they possess. An actor may fumble his lines, but a lawyer needs to be letter-perfect; at least, he has to use his wits, and he may forget himself, and often does, but never for a moment can he lose sight of his client."[60]

"Twelve men, good and true" (who likely do not know you or your resident/client) must be persuaded that your client was injured because the nursing home staff did something wrong. You are seeking a verdict for your client and they will not give it to you unless you reach them.[61] You will not reach the jury unless you develop and communicate a simple, clear, concise message. Paint a picture for them. Your message should be humanized, told in story form, and in a manner that an elementary school student would understand. You do that by, first, learning your client's story and then by learning how to tell it.

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[60] C. Darrow, Attorney for the Defense: How to Pick a Jury, in Verdicts out of Court, at 314 (Elephant Paperbacks 1989).

[61] Of course, you will not reach them if you bore them. For example, in People v. Matiash, 602 N.Y.S.2d 977 (N.Y. App. 1993), the jurors felt that the lawyers were boring and that they simply dragged things out.

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> "At its core, *storytelling is the art of using language, vocalization, and/or physical movement and gesture to reveal the elements and images of a story to a specific, live audience*. A central, unique aspect of storytelling is its reliance on the audience to develop specific visual imagery and detail to complete and co-create the story. ... Most dictionaries define a story as *a narrative account of a real or imagined event or events*. Within the storytelling community, a story is more generally agreed to be a specific structure of narrative with a specific style and set of characters and which includes a sense of completeness. Through this sharing of experience we use stories to pass on accumulated wisdom, beliefs, and values. Through stories we explain how things are, why they are, and our role and purpose. Stories are the building blocks of knowledge, the foundation of memory and learning. Stories connect us with our humanness and link past, present, and future by teaching us to anticipate the possible consequences of our actions."[62]

All good stories have actors and action centered by a plot, moving toward a conclusion. The most memorable stories build with suspense toward a good climax.[63] In litigation, the story should work toward a conclusion, which, if told properly, empowers your jury to make a difference.[64] You empower the jury by helping them understand how a verdict for the Plaintiff will improve the quality of care delivered, either for the resident (if living) or for other residents still at the facility. Alternatively, reach the verdict sought by educating the jury concerning why the Defendant is evil and should be punished.[65] Neither of these objectives will occur if you fail

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[62] What is Storytelling: An Attempt to Define the Art Form, available at http://www.eldrbarry.net/roos/st_defn.htm (Emphasis in original). See also National Storytelling Network, http://www.storynet.org/.

[63] A. Chan, The Art of the Storyteller, The Leader (1987), available at http://www.eldrbarry.net/roos/storytel.htm.

[64] The story must also be internally consistent. D. Wenner, Preparing for Trial: An Uncommon Approach, in Overcoming Juror Bias (ATLA, September 2001). Among the questions you should consider is whether the Plaintiff's story explains all of the evidence, are there inconsistent facts, is the story believable, and is the story complete (does it have a beginning, middle and end)? Id. Always remember that your story will be measured against common sense. "Jurors will not suspend their belief and adopt your reality. If the story does not make sense, it will be rejected." Id.

[65] A Louisiana lawyer, whose name escapes me or I would give credit, described his case outline in a single word: POP. If the event is **P**redictable, and is **O**bservable, then it is **P**reventable. This fits with what jury consultants tell us about how juries decide cases. Among other factors, they want to know which party had true

to develop and communicate a clear message.[66] Going one step further (and taking a page from Madison Avenue), you will not accomplish your objectives *unless* you reach the jury on an emotional level - virtually all advertising (the art of persuasion honed to its finest point) appeals to the emotions.[67]

When considering how to educate your jury, you must find a way to show them what changed as a result of the Defendant's wrong-doing. To do that, you must establish a base-line, which is the Plaintiff's condition prior to his/her encounter with the Defendant. The resident's condition post-injury is then measured against that base-line and that difference, together with an evaluation of the pain the resident suffered,[68] is your measure of damages. How did the resident's injury affect his or her prognosis, life span and ability to enjoy life? The information

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power to change events.

[66] Again, part of sending a clear message is telling a complete story, using a framework that is easily followed. Often, a story told chronologically makes the most sense. Voids in the story will be filled – if you leave gaps in your story, jurors will fill those gaps with their own life experiences. D. Werner, The Ten Commandments of Juror Bias, in Overcoming Juror Bias (ATLA, September 2001). See also Darrow, How to Pick a Jury, supra.

[67] "The most important point to learn [in selecting the twelve most likely to deliver such a verdict] is whether the prospective juror is humane." Darrow, How to Pick a Jury, supra, at 317.

[68] Obviously, pain caused by injury is an element of damages. However, a nursing home's failure to assess and treat pain should also be actionable. "About one in four persons in the nursing home who are in daily pain are not treated with the most basic treatment, Tylenol or Aspirin." J. Teno et al., The Prevalence and Treatment of Pain in US Nursing Homes, at 31 (Center for Gerontology and Health Care Research, Brown University RWJF # 036185), available at http://www.chcr.brown.edu/commstate/PAINMONOGRAPHWEBVERSION.PDF. "Pain is prevalent and under-treated in the nursing home setting. To improve this, nursing home staff must undertake more complete and comprehensive assessments of pain to inform the development of pain management plans for all patients." Id., at 5. "The presence of pain in elderly patients and nursing home residents has been associated with depression, decreased socialization, sleep disturbance, impaired ambulation, and increased health care use and costs ... Many geriatric conditions are worsened by the presence of pain including deconditioning, gait disturbances, falls, slow rehabilitation, polypharmacy, cognitive disfunction, and malnutrition. ... Moreover, residents experiencing pain may also have difficulty making their needs known, which in turn may cause agitation." Id., at 8. "Failure to prevent and/or treat pain effectively is not acceptable and should be considered an indicator of poor quality of medicine." Id., at 9. "Pain is not a normal part of aging." Id., 24. See also Facts on Dying 2002: Nursing Home Residents With Severe Pain - State-by-State (Brown University 2002) (available on the internet); and see L. McClaugherty, Chronic Pain: We're Undertreating the Elderly, 51 Nursing Homes Magazine 58 (August 2002); Chronic Pain Management in the Long-Term Care Setting: Clinical Practice Guidelines (AMDA 1999).

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necessary to communicate this change in condition will, in large part, come in through testimony from expert witnesses, and from friends and family of your client. This is much of the material from which you will develop your human drama.

For more on developing a theory of the case, see J. McElhaney, The Theory of the Case, in McElhaney's Trial Notebook, 77-84 (ABA 1994). For specific themes regarding nursing home cases, see R. Krizstall, Nursing Home Litigation (Lawyers & Judges Publishing). See also P. Iyer, Presentation of Evidence in Nursing Home Cases, in L&J Nursing Home Litigation Seminar (Lawyers & Judges Publishing, October 26 & 27, 2001).[69]

A Word Concerning Motions, Common Defenses & Framing Discovery

When preparing your case, you should assume the Defendant will file motions to dismiss and motions for summary judgment. Their purpose will be to limit the scope of your client's claims, to pare down the issues that are relevant (and therefore, admissible) at trial, or for discovery (forcing you to show your cards). You will successfully respond to the motion by showing that a material issue of fact is in controversy. By responding to Defense motions successfully, you reach the jury.

Since you know the Defendant's motion will be filed, you should prepare all discovery, informal and formal, anticipating Defense motions. You should design your discovery to establish facts supporting each element of the prima facie case for each count in your

[69] Although Ms. Iyer is not an attorney, she has many good ideas. The point to be gleaned is look for good story telling ideas from numerous sources. The legal profession does not have a patent on communication skills. Truth be told, often non-lawyers communicate better than lawyers and we should take note of their ideas.

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Complaint.[70] Borrowing an expression from the movie industry, the trial judge will "edit" each claim where you fail to develop a prima facie case, and that part of your case will wind up on "the cutting room floor."

The standard for a court to dismiss a claim is whether it appears beyond doubt that the plaintiff can prove no set of facts to support his claim.[71] The principal Georgia case outlining the summary judgment standard is Lau's Corp. v. Haskins, 261 Ga. 491 (1991). Again, you survive both motions by doing your homework, developing the facts necessary to prove you case.

Many nursing home defendants (whether they admit it or not) know they breached the standard of care and, thus, defenses do not always attack the legal issues. Often they are aimed at damages or at the resident or his or her family. You should also assume defenses of that type will be presented and prepare the client appropriately.[72] Among defenses that are common are the following:

- The resident caused his or her own injury.
- The resident was going to die anyway. The injury was due to a
- Sudden onset, irreversible condition or was unavoidable.
- The resident's death or injury was caused by some other event or pre-existing disease process.

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[70] Conversely, the party who will not have the burden of proof at trial discharges their burden by pointing out the absence of evidence to support the nonmoving party's case. See HCP III Woodstock, Inc. v. Healthcare Services Group, Inc., 254 Ga. App. 242, 244 (2002). Once done, the nonmoving party cannot rest on its pleadings, but must point to specific evidence giving rise to a triable issue. Id.

[71] Brogdon et al. v. National Healthcare Corporation, 103 F. Supp.2d 1322, 1326 (2000). All well-pleaded facts are accepted as true. Id.

[72] This does not mean trying to change the facts. See e.g., Georgia Rules of Professional Conduct, Rule 3.3; Tennessee Rules of Professional Conduct, Rule 3.3

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- G The cause of death is speculative because the family did not secure an autopsy.
- G Money cannot bring the resident back (and the family is greedy).
- G The family is just grieving, looking for someone to blame.
- G The family did not really have a quality relationship with the resident.[73]
- G Other health care providers caused the resident's injuries.
- G There was no breach of the standard of care because everyone does it.
- G The facility owed no duty to the resident.
- G The resident did not experience pain due to dementia or vegetative state.

Themes & Theories: Common Claims Against Nursing Homes

Ultimately the theme of your case will be driven by the nursing home's conduct and by your client's injury. However, as you weave the theme, keep in mind that rarely has a juror attended medical school, law school or resided in a nursing home. Because jurors will not have technical expertise concerning how nursing home care should be provided, they may relate best to larger issues like "the nursing home didn't do what they were supposed to do", greed, the Defendants' refusal to accept responsibility, bad faith, betrayal of trust, arrogance and indifference. These are themes that anyone can understand, and if they fit the facts of your case, they may lead to punitive damage claims. Beyond these themes, the burden is on you to educate the jury concerning the technical aspects of your client's specific case.

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[73] Photographs of family members visiting the resident in the nursing home should be secured whenever they exist to counter this defense. Other documents similarly useful may be nursing home visitor sign-in sheets, records showing participation in family council meetings and records showing participation in care plan meetings.

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Nursing home care is generally provided by the nursing staff. "It is the responsibility of the nurse to provide quality care to the resident, maintain a safe environment, provide supervision to the paraprofessional staff involved with the care of the residents, and maintain open lines of communication with the residents' physicians, and others involved in their care."[74] Among relevant standards, nurses are guided by O.B.R.A. regulations, state laws and regulations, nursing home policies and procedures, practice standards established by the American Nurses Association, and JCAHO Long Term Care standards, and specific protocols such as clinical practice guidelines relating to wound care. The care plan itself may establish a standard of care. You prove the negligence portion of your case by showing how the nursing home staff fell below the standard of care, most likely, in one of the following areas:

1. Failure to Assess/Inadequate Care Plan:

> *"Your thorough assessment and the diagnosis you reach are the crucial foundation of care." Mastering Geriatric Care 17 (Spinghouse Corporation 1997).*

Assessment:

"Assessment is the first step in the nursing process and includes the systematic collection, verification, organization, interpretation, and documentation of client data."[75] Care without assessment is like shooting arrows without a target – or worse, like wandering in the dark. (Would you, for instance, draw and execute contracts for your client without first investigating

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[74] K. Anderson, Medical Issues in Nursing Home Litigation 2, in Nursing Home Negligence [I]: Asserting Claims & Defending Nursing Homes (PESI 1999).

[75] L. White, Documentation & the Nursing Process 15 (Thomson/Delmar Learning 2003). See also M. Lubin & P. Iyer, Subacute and Long-Term Care Nursing Malpractice Issues, in Nursing Malpractice, Second Edition, at 426 (Lawyers & Judges Publishing 2001).

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your client's position and needs?).[76] Thus, assessment informs the staff concerning resident needs and thereby improves care and clinical outcomes.[77] Assessment and care planning are the keys to good care.[78]

"Geriatric assessment differs from a standard medical evaluation by including nonmedical domains, by emphasizing functional ability and quality of life, and often, by relying on interdisciplinary teams."[79] The most successful assessments employ a multi-disciplinary approach, involving a geriatric physician, a nurse, a social worker and a pharmacist.[80]

Federal and State law and regulations require that the nursing home perform a complete and accurate assessment. The federal statute and regulations are as follows:

> A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment (i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity; (ii) is based on a uniform minimum data set specified by [CMS]; (iii) uses an instrument which is specified by [CMS]; and (iv) includes the identification of medical problems. 42 U.S.C. § 1396r(b)(3)(A).

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[76] "Nursing homes must conduct an assessment of each resident. This evaluation is the basis for planning that individual's care. Just as its necessary to look at a map to plan your route before you head out on a trip, assessment and care planning are meant to give the staff direction in working with each resident." S. Burger, et al., Nursing Homes: Getting Good Care There, Second Edition 16 (National Citizens' Coalition for Nursing Home Reform 2002).

[77] The Merck Manual of Geriatrics, Third Edition 40 (Merck 2000).

[78] Nursing Homes: Getting Good Care There, supra, at 38; see also discussion of assessment and care planning at pages 38 through 57.

[79] Id.

[80] Id., at 42, 74-84. Interestingly, Merck agrees that a pharmacist should be involved in the assessment.

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> The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. 42 CFR § 483.20. The facility must use the Resident Assessment Instrument (RAI) specified by the State,. 42 CFR § 483.20(b)(1), which must include at least the following: (i) identification and demographic information; (ii) customary routine; (iii) cognitive patterns; (iv) communication; (v) vision; (vi) mood and behavior patterns; (vii) psychological well-being; (viii) physical functioning and structural problems; (ix) continence; (x) disease diagnoses and health conditions; (xi) dental and nutritional status; (xii) skin condition; (xiii) activity pursuit; (xiv) medications; (xv) special treatments and procedures; (xvi) discharge potential; (xvii) documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and (xviii) documentation of participation in assessment. Id.

The assessment process include use of the standard assessment instrument, the Minimum Data Set ("MDS") and the Resident Assessment Instrument ("RAI").[81] As otherwise detailed herein, the MDS is a core document used to identify resident issues and needs. The RAI is a series of 18 instruments (Resident Assessment Protocols or "RAPs") used to further explore the resident's specific needs. Together, they comprise the comprehensive resident assessment required under OBRA.

"Deviations from the standard of care can occur when the nursing staff fails to accurately assess the resident's needs, fails to diagnose the problems, or fails to implement a plan of care to address the needs."[82] Thus, because a claim based on a failure to assess is one where the nursing staff dropped the ball, it is similar to a mis-diagnosis claim because the resident's needs were overlooked. In mis-diagnosis cases, the standard in Georgia is stated as follows: "the degree of care and skill required for treatment is that degree of care and skill required which under similar conditions and like surrounding circumstances is ordinarily employed by the profession

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[81] The nursing home must use a standardized assessment instrument (the "MDS"). See 42 CFR § 483.315(e). The assessment required under Federal law is the one prescribed in the Merck Manual of Geriatrics. See Merck Manual, supra, pp. 42-46. Thus, it restates rather than sets the applicable standard. For a detailed description of how the assessment should be performed, see Handbook of Geriatric Nursing Care 55-84 (Springhouse Corp. 1998)

[82] Lubin & Iyer, supra.

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generally."[83] O.B.R.A. regulations[84] set the standard of care for the nursing home profession since virtually all nursing homes must comply with them. Generally, Georgia nursing homes must comply with O.B.R.A. because more than 80% of Georgia nursing home residents are on Medicaid.[85]

Beyond its ramifications relating to proper treatment, the assessment is linked to other resident rights such as the right to refuse certain discharges and transfers. In Matter of the Involuntary Discharge or Transfer of J.S. by Hall, 512 N.W.2d 604 (Minn App 1994), a nursing facility attempted the involuntary discharge of a 74 year old resident with a history of mental illness. The reason given by the facility was its inability to meet the resident's needs. However, before the nursing home can demonstrate its inability to meet the resident's needs, it must first show that it adequately assessed them. Id., at 612. The Court rejected the nursing home's argument holding that involuntary transfer or discharge must be a last resort, pursued only after the facility exhausts its treatment options. Id.

The Care Plan:

After the assessment is completed, the nursing home must develop a plan of care. The plan must be in writing and must describe how the resident's assessed needs will be met. The Federal statute is as follows:

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[83] See Royal & Alexander, supra, § 2-2.

[84] 42 CFR 483.1 et seq.

[85] "The true rule is that the reasonable degree of care and skill prescribed in the Code is not such as is ordinarily employed by the profession in the locality or community. It is a question of fact for the jury to determine what is reasonable care and skill under the circumstances, and in so determining the jury may consider the degree of care and skill practiced by the profession generally in the locality or the community." Mull v. Emory University, Inc., 114 Ga. App. 63 (1966). Regarding Georgia nursing home residents on Medicaid, see Georgia Nursing Home Association website, at http://www.gnha.org/choose.htm#pay.

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> A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental and pyschosocial well-being of each resident in accordance with a written plan of care which (A) describes the medical, nursing and pyschosocial needs of the resident and how such needs will be met; (B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which include the resident's attending physician and a registered professional nurse with responsibility for the resident; and is periodically reviewed and revised by such team after each assessment. 42 U.S.C. § 1396r(b)(2). See also 42 CFR 483.20(k).

A good care plan is specific, individualized and written in language that a lay person can understand. It reflects the resident's concerns and preferences, supports the resident's well-being, ability to function and rights, is prepared using an interdisciplinary approach and changes as the resident's needs change.[86] Conversely, a bad care plan is written in medical terminology with general goals and approaches that do not address the resident's preferences or individuality, ignores the resident's ideas or wishes, labels resident choice as a behavior problem, is not interdisciplinary and does not change over time.[87]

The plan of care must then be followed or implemented. Nursing care shall be provided each patient according to his needs and in accordance with his patient care plan. Ga. Regs. § 290-5-8-.10(8). The assessment, care planning and treatment is a dynamic process that must change with the resident's needs.

In reviewing the assessment and plan of care, keep the following in mind: failure to follow the standard of care in properly assessing a resident and developing a comprehensive care plan can demonstrate that the nursing home just doesn't care. It may show that the nursing facility knew the standard of care applicable to your client/resident and failed to follow it. If the care plan was not followed, in legal terms, the facilities own documents are evidence showing

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[86] Nursing Homes: Getting Good Care There, supra, at 42-43.

[87] Id.

duty and breach, and buttress your punitive damage claim by showing callous disregard to the consequences.

2. Staffing and Claims of Systemic Neglect:

> The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. 42 CFR § 483.30.

"The vast majority of poor clinical care results from inadequate staffing and inadequate quality assurance measures."[88] Understaffing can lead to abuse, malnutrition, dehydration, falls, medication errors, inaccurate assessment and charting, pressure ulcers and other neglect.[89] The facility must have sufficient qualified staff present to meet resident needs on a twenty-four hour basis. If it does not, Surveyors are instructed to cite a deficiency.[90]

We frequently hear family members complain that only one or two CNAs are present to care for an entire hall or wing. Family will look for a nurse to address a patient need and no nurses are found. Family members tell us that staff turn-over is high and that they are always seeing new faces. We often hear that CNAs take frequent breaks (e.g., they congregate on the back porch to smoke). Food is delivered cold and, when the patient is diabetic, meals come

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[88] M. Solomon, Proving Systemic Failures Using Quality Indicators, 1 The Advocate 1 (ATLA Nursing Home Litigation Group 2001).

[89] H. Fillmore, Proving and Demonstrating the Effects of Inadequate Staffing and Abuse, in Litigating Nursing Home Cases (ATLA March 17-18, 2000). See also Survey Procedures for Long Term Care Facilities, Investigation Protocol Nursing Services, Sufficient Staff, at P-51.

[90] Survey Procedures for Long Term Care Facilities, Investigation Protocol Nursing Services, Sufficient Staff, at P-52. The specific Tag is F353.

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hours after insulin is administered.[91] Medicine arrives late. Residents are diapered and ignored.[92]

In Georgia, the nursing home must provide specific staffing as follows: Each nursing home must employ at least one registered nurse to serve as the Director of Nursing Services.[93] At least one nurse, registered, licensed practical undergraduate, or licensed practical shall be on duty and in charge of all nursing activities each eight hour shift.[94] "There shall be sufficient nursing staff on duty at all times to provide care for each patient according to his needs. A minimum of 2.0 hours of direct nursing care per patient in a 24 hour period must be provided. For every seven (7) total nursing personnel required, there shall be not less than one registered or licensed practical nurse employed." Ga. Regs. § 290-5-8-.04(5).[95] There shall be sufficient qualified

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[91] "Insulin's role in the body is to transport glucose into the cells for fuel or for storage as glycogen." Handbook of Geriatric Nursing Care, supra, p. 215. "A deficiency of insulin compromises the body's ability to access essential nutrient for fuel and storage." Id. In that regard, timing insulin therapy to mealtimes is critical for good diabetics health. Although different insulin types have different release times, typically insulin is most effective when given within 30 minutes of mealtime. Persons with diabetes do not produce enough natural insulin to regulate their blood sugar. Insulin lowers blood sugar when it to too high. See generally, American Diabetes Ass'n website, at www.diabetes.org. Normal fasting blood sugar is between 80 and 120 mg/dl, and should be between 100 and 140 ml/dl at bedtime unless another target is set by the attending physician. See American Diabetes Ass'n website. High blood sugar, hyperglycemia, causes many of the complications associated with diabetes, which include eye, nerve and kidney disease. See American Diabetes Ass'n, http://www.diabetes.org/main/application/commercewf?origin=*.jsp&event=link(C3). It can also lead to a life threatening condition known as ketoacidosis. Hypoglycemia (low blood sugar) is a side effect of insulin therapy that can occur following an error in dosage, a small or missed meal, or unplanned exercise. See Merck Manual of Geriatrics, at http://www.merck.com/pubs/mm_geriatrics/sec8/ch64.htm. Proper timing of meal and insulin administration achieves balance. Symptoms of hypoglycemia include "shakiness; dizziness; sweating; hunger; headache; pale skin color; sudden moodiness or behavior changes, such as crying for no apparent reason; clumsy or jerky movements; difficulty paying attention, or confusion; tingling sensations around the mouth." See American Diabetes Ass'n, http://www.diabetes.org/main/application/commercewf?origin=*.jsp&event=link(C4_5). Diabetics should consult a doctor if blood sugar falls below 50 mg/dl without symptoms, or if it exceeds 240 with ketones. Criteria for diagnosing Type II Diabetes Mellitus in the elderly are in the Handbook on Geriatric Nursing Care and in the Merck Manual of Geriatrics, at http://www.merck.com/pubs/mm_geriatrics/tables/64t1.htm.

[92] This type of "care" violates 42 CFR 483.25(a)(1).

[93] 42 CFR § 483.30((b)(2); Ga. Regs. § 290-5-8-.04(1).

[94] 42 CFR § 483.30(a)(2); Ga. Regs. § 290-5-8-.04(4).

[95] See also 42 CFR § 483.30((a)(1).

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personnel in attendance at all times to insure properly supervised nursing services to patients. This includes staff members dressed, awake and on duty all night. Ga. Regs. § 290-5-8-.04(7).[96] In other words, assessments must be performed to see that staffing is keyed to the individual needs of the residents rather than the perceived needs of the nursing home. Staffing is inappropriate if it is simply a budget related numbers game.[97]

Not only must the staff be present, they must be present in sufficient numbers, they must be qualified and must be equipped to do the job. For example, third shift and weekend staffing ratios are frequently lower than Monday through Friday first and second shift staffing. Are sufficient staff present to feed persons who need assistance? Are sufficient staff present to turn residents who are at risk for development of pressure ulcers? Is there a wound care nurse and what are that nurse's qualifications? Are call systems in place to alert staff to resident needs? Ga. Regs. § 290-5-8-.18(11).[98]

There are only 480 minutes during each eight (8) hours shift. Nursing home lawyer Leslie Clement estimated, assuming each CNA ***should***: give 4 to 5 showers, 5 bed baths, help 5 feeders, empty or measure 1 catheter, help at least 7 incontinent residents, chart at least 11 residents, make at least 11 beds, set up at least 9 food trays, help at least 8 residents with toileting, and help at least 9 to 12 residents with grooming, 872 minutes would be necessary to

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[96] See also 42 U.S.C. § 1396r(b)(4)(A) (services that must be provided); and (b)(4)(B) (services must be provided by qualified persons); 42 CFR 483.75(g)(1); Guide to Surveyors, supra, Tag F499. Georgia regulation 290-5-8-.04(7) might come into play in a case like Riley v. Maison Orleans II, Inc., 2002 WL 31256411 (La. App. 4 Cir. September 25 2002), where nursing staff were asleep while one resident found a steel pipe and used it to beat another resident.

[97] W. Cunningham, Theories of Negligence Against Nursing Homes, E1-E3, in Litigating Nursing Home Cases (ATLA March 17-18, 2000).

[98] This doesn't end the inquiry though. We frequently hear that call lights are not answered.

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perform typical duties.[99] Obviously, a CNA with these duties cannot finish the job. The proper response is for the nursing home to hire additional staff. In our experience, however, staffing is bare-boned and each CNA is often responsible for 30 (or more) residents.

For more information regarding staffing cases, see B. Arbeit, Selected Strategies Toward Analysis of Nursing Department Staffing in A Nursing Home Case.[100]

3. Malnutrition and Dehydration:

Malnutrition:

Malnutrition is a deficiency syndrome caused by inadequate intake or absorption of macronutrients.[101]

There is no uniformly accepted definition of malnutrition in older persons.[102] Among various measures commonly used are involuntary weight loss (e.g., greater than 10 pounds in 6 months), abnormal body mass, hypoalbuminemia, hypocholesteremia and specific vitamin or micronutrient deficiencies.[103]

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[99] L. Clement, The Typical Duties of a Day Shift CNA, 1 The Advocate 4 (ATLA Nursing Home Litigation Group May 2001). Ms. Clement's estimate exclude time necessary for hand washing, vital signs, passing out nourishments, answering questions, answering call lights, finding wandering residents, helping residents get in or out of bed, getting water for residents, talking with residents and answering family member questions. Ms. Clement, of Clement & Associates, 2209 J STREET, Sacramento, CA 95816; (916) 444-9323 laclaw@cwnet.com; elderabuseadvocates.com. Ms. Clement, a past president of ATLA's Nursing Home Litigation Group, handled her first elder abuse case in 1994 and since that time she has focused her energies representing abused elderly and dependent adults throughout California.

[100] Mr. Arbeit's paper has been published at several CLE conferences, among them ATLA's Litigating Nursing Home Cases Part I (ATLA, Houston Texas April 20-21, 2001). He can be reached at 5436 Avenida Del Mare, Sarasota, Florida 34242; (941) 346-9440.

[101] Merck Manual, supra, 595.

[102] D. Reuben et al., Geriatrics at Your Fingertips Online Edition (American Geriatrics Society), at http://www.geriatricsatyourfingertips.org/ebook/10015047_chapter_18.asp.

[103] Id.

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Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and receives a therapeutic diet when there is a nutritional problem. 42 CFR § 483.25(i).[104]

The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident. 42 CFR § 483.35. The facility must employ sufficient staff competent to provide dietary service. 42 CFR § 483.35(b).[105] Menus must meet nutritional needs of the residents, must be prepared in advance and must be followed. 42 CFR § 483.35(c).[106] Food must be prepared by methods that conserve nutritive value, flavor and appearance; must be palatable, attractive and at the proper temperature; must be prepared in a form designed to meet the individual needs of the residents; and substitutes must be offered of similar nutritive value to residents who refuse food served. 42 CFR § 483.35(d). The facility must provide each resident with three meals daily, at regular times, comparable to normal mealtimes in the community and must offer snacks at bedtime daily. 42 CFR § 483.35(f). Assistive devices must be offered to residents who need them. 42 CFR § 483.35(g).

Unplanned weight loss may indicate unacceptable nutritional status and should trigger an assessment. Also indicative of poor nutritional status are peripheral edema, cachexia and

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[104] "The intent of this regulation is to assure that the resident maintains acceptable parameters of nutritional status, taking into account of the resident's clinical condition or other appropriate intervention, when there is a nutritional problem." Guidance to Surveyors - Long Term Care Facilities Guide to Survey Tag Numbers, Appendix PP, at PP-106, available at CMS website. See also Ga. Regs., § 290-5-8-.06(5).

[105] The facility must employ the services of a qualified dietitian for at least eight hours each month. Ga. Regs., § 290-5-8-.06(1).

[106] Ga. Regs., § 290-5-8-.06(3) and (4).

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laboratory tests indicating malnourishment.[107] Clinical observations that may indicate malnutrition include pale skin, dull eyes, swollen lips, swollen gums, swollen and/or dry tongue with scarlet or magenta hue, poor skin turgor, cachexia, bilateral edema, and muscle wasting.[108]

Weight loss is a guide in determining nutritional status. Weight loss should be noted and addressed in the resident's care plan where there is a five percent (5%) or more loss of total body weight during one month, seven-and-one-half percent (7.5%) or more loss of total body weight during three months, or ten percent (10%) or more loss of total body weight during six months.[109]

Nursing Home Surveyors are instructed to determine:

1. Whether the facility identified factors that put the resident at risk for malnutrition?

2. If the resident triggered RAPs for nutritional status, ADL functional/rehabilitation potential, feeding tubes, psychotropic drug use, and dehydration. Consider whether the RAPs were used to assess the causal factors for decline, potential for decline or lack of improvement?

3. What routine preventative measures and care did the resident receive to address unique risk factors for malnutrition?

4. Were staff responsibilities for maintaining nutritional status clear, including monitoring the amount of food the resident is eating at each meal and offering substitutes?

5. Was this care consistently provided?

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[107] Guide to Surveyors, supra, Tag F325, at PP-106. Albumin for a resident over the age of 60 should range between 3.4 and 4.8; plasma transferrin should range between 180 and 380; Hemoglobin should range between 14 and 17 for males and 12 to 15 for females; Hematocrit should range between 41 and 53 for males, and 36 to 46 for females; Potassium should range between 3.5 and 5.0; Magnesium should range between 1.3 and 2.0. Id.

[108] Id.

[109] Guide to Surveyors, supra, Tag F326, at PP-106. Other clinical triggers include leaving more than 25% of food in past week for 2/3 of meals (based on a 2000 calorie diet) and a body mass index equal to or less than 21. See S. Castle & J. Braun, Use of Experts in Nursing Home Litigation: Perspective of the Medical Expert.

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6. Were alternative goals of the plan of care periodically evaluated and if not met, were alternative approaches considered or attempted?[110]

Questions for family members include whether the resident's clothing was fitting more loosely, whether there are cracks around the resident's mouth, whether lips and mouth look pale, whether the resident's false teeth still fit, when the resident started losing weight and is the resident's skin breaking down?[111] Further, if "Mom" needed assistance eating, was assistance provided?[112] Were her taste preferences addressed? Was she given enough time to eat? If she seemed uninterested in the food, was that noticed and addressed?[113]

> *In numerous cases we have reviewed, food trays were left for residents who require assistance eating, but no assistance was provided. In one case, where the resident suffered a stroke and had left side paralysis, family reported that food trays were often left on the resident's left side. Unless family were present to assist the resident, the food remained uneaten when the tray was picked up by staff.*

Numerous resources exist outlining nutrition for the Elderly. Among them, see H. Munro & D. Danford, Nutrition, Aging, and the Elderly, Volume 6 in Human Nutrition: A Comprehensive Treatise (Plenum Press 1989); J. Braun and E. Capezutti, A Medico-Legal Evaluation of Dehydration and Malnutrition Among Nursing Home Residents, 8 Elder Law Journal ____ (2000); and Handbook of Geriatric Nursing Care 389-393 (Springhouse Corp. 1998).

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[110] Guide to Surveyors, supra, Tag F326, at PP-108.

[111] Nursing Homes: Getting Good Care There, supra, at 64.

[112] "Activity related to feeding of impaired residents occupies 4 to 53 minutes, with an average of 20 minutes." S. Castle & J. Braun, Use of Experts in Nursing Home Litigation: Perspective of the Medical Expert.

[113] Id.

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Dehydration:

> The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. 42 CFR § 483.25(j).

> *"Dehydration is a significant cause of mortality in the elderly. Studies have demonstrated that the mortality rate may exceed 50% in hospitalized dehydrated patients. Other clinical studies have shown that as many as 50% of patients admitted with a primary diagnosis of dehydration die within 1 year after discharge."*[114]

According to Surveyor Guidelines, "Sufficient fluid" means "the amount of fluid needed to prevent dehydration (output of fluids far exceeds fluid intake)."[115] This is an individual assessment, specific to each resident.[116] Risk factors for dehydration include coma/decreased sensorium, fluid loss and increased fluid needs (e.g., diarrhea, fever, uncontrolled diabetes), fluid restrictions secondary to dialysis, functional impairments that make it difficult to drink, reach fluids or communicate fluid needs, dementia (forgetting need for fluid), and refusal of fluids.[117] Each of these risk factors should be charted in the resident's MDS and their presence should trigger a RAPs on hydration.

Signs and symptoms of dehydration include altered mental status (confusion and disorientation), tachycardia, lethargy, light-headedness, syncope, constipation, dry skin, reduced skin turgor, dry mucous membranes, cracked lips, thirst, fever and abnormal laboratory values.[118]

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[114] J. Cacciamani & E. Schwab, Deydration, in Geriatric Secrets, Second Edition, pp. 268 to 271 (Hanley & Belfus, Inc. 2000).

[115] Guide to Surveyors, supra, Tag F327, at PP-109..

[116] Id.

[117] Id.

[118] Merck Manual, supra, 562; Cacciamani & Schwab, supra, at 268; Guide to Surveyors, supra, Tag F327.

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Severe dehydration can cause orthostatic hypotension, leading to shock.[119] Inadequate re-hydration that is not accomplished quickly can lead to serious conditions, including renal failure, heart attack, stroke, and rhabdomyolysis.[120]

Among steps that can be taken to prevent dehydration, residents can drink 8 glasses of water per day during hot weather and can be kept out of direct sunlight.[121] Most of us have been told repeatedly to drink eight glasses of water each day for good health. Other basic preventative measures include helping residents with special needs, providing special cups, providing fluids other than water and monitoring intake and output.[122] Given the simplicity of these basic measures, there seem to be few excuses for dehydration.

4. Pressure Ulcers:

> Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 42 CFR 483.25(c).

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[119] Id. Orthostatic hypotension is an excessive fall in BP (typically > 20/10 mm Hg) on assuming the upright posture. See The Merck Manual, http://www.merck.com/pubs/mmanual/section16/chapter200/200a.htm. Hypovolemia (diminished blood volume) is the most common cause of orthostatic hypotension. Id. Shock is a state in which blood flow to and perfusion of peripheral tissues are inadequate to sustain life because of insufficient cardiac output or maldistribution of peripheral blood flow, usually associated with hypotension and oliguria. Merck Manual, http://www.merck.com/pubs/mmanual/section16/chapter204/204a.htm.

[120] Id., at 563.

[121] Cacciamani & Schwab, supra, at 271. Also, on hot days, residents should be kept cool and the best way to do that is to stay inside an air conditioned home. Id. See also 42 CFR 483.15(h)(6) (facility temperature must be maintained between 71 and 81 degrees). Other methods of preventing dehydration are outlined at Handbook of Gerratric Nursing Care 391 (Springhouse Corp. 1998).

[122] Handbook of Geriatric Nursing Care, supra, 391.

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Pressure ulcers are the clinical manifestations of local tissue death.[123] External pressure that is greater than capillary perfusion pressure causes ischemia. Pressure ulcers can form when a nursing home resident constantly maintains any position.[124] Simply put, pressure plus time equals the development of pressure ulcers. Prediction is simple: pressure plus time equals pressure ulcers.

Pressure ulcers are typically described in four stages as follows:[125]

> **Stage I**: Nonblanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators.
>
> **Stage II**: Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater.
>
> **Stage III**: Full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue.
>
> **Stage IV**: Full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule). Undermining and sinus tracts also may be associated with Stage IV pressure ulcers.

"The treating health care practitioner and nursing staff should identify and document [risk] factors at the start of treatment. Relevant physical factors include those causing or contributing to the wound's development and those that may impact the wound's healing and the

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[123] J. Maklebust & Mary Sieggreen, Pressure Ulcers: Guidelines for Management & Prevention, Third Edition 19 (Springhouse Corporation 2001). Common terms for tissue destruction resulting from prolonged pressure are "bedsores", "decubitus ulcers", "pressure sores" and "pressure ulcers". Id., at 13. They are also called "dermal ulcers." See National Pressure Ulcer Advisory Panel, Statement on Pressure Ulcer Prevention (1992), available at www.npuap.org.

[124] Maklebust & Sieggreen, supra, at 13

[125] Clinical Practice Guideline Number 15: Treatment of Pressure Ulcers (available on the internet).

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development of related complications."[126] Among factors that play a role in pressure ulcer formation are shear, friction, excessive moisture and infection.[127] Nursing literature is replete with information concerning proper care for pressure ulcers. The following is an exemplar list from the Handbook of Geriatric Nursing Care[128] identifying residents at risk for the development of pressure ulcers – Residents with

7. poor circulation
8. diabetes mellitus
9. malnutrition
10. immunosuppression
11. dehydration
12. incontinence
13. significant obesity or thinness
14. paralysis
15. diminished pain awareness
16. history of corticosteriod therapy
17. chronic illness that requires bed rest
18. mental impairment
19. use of residents.

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[126] American Medical Directors Assn., Pressure Ulcer Therapy Companion (1999), at http://www.guideline.gov/VIEWS/summary.asp?guideline=1385&summary_type=brief_summary&view=brief_summary&sSearch_string=.

[127] Id., 19, 24-26.

[128] Handbook of Geriatric Nursing Care, supra, 466.

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Signs and symptoms of pressure ulcers include shiny, erythematous changes over the compressed area in early superficial legions; small blisters or erosions and ultimately necrosis and ulceration; inflamation; infection; foul-smelling, purulent discharge; and black eschar.[129]

The Braden Scale and the Norton Scale are two common tools used to evaluate pressure ulcer risk.[130] A third assessment tool is the Gosnell Scale.[131]

Because the cause of pressure ulcers is known, most pressure ulcers are treatable and preventable.[132]

In Brown v. DeKalb Medical Center, 225 Ga. App. 4 (1997), the Plaintiff filed an action alleging negligence relating to the treatment of pressure ulcers. Plaintiff's expert testified that patients with poor circulation (which the resident had) do not develop pressure ulcers if adequate nursing care is given. There was evidence that pressure ulcers developed and, therefore, the evidence allowed the jury to find that the nursing home negligently failed to prevent the pressure ulcers from developing.

5. Dignity Claims and Statutory Claims (Negligence *per se*):

> "Understanding each resident also involves understanding his or her legal rights related to how care is given in long term facilities. You must become familiar with these rights because you are accountable for protecting each resident's rights." *M. Casey, How To Be A Nurse Assistant: Career Training in Long Term Care, at 28 (AHCA 1995).*

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[129] Handbook of Geriatric Nursing Care, supra, 469.

[130] See e.g., Braden Scale, at http://hstat.nlm.nih.gov/hq/Hquest/action/GetText/hitno/228/query/pressure+ulcer+guideline/fws/S/lhit/231/searchid/1038107254693/screen/Browse/db/local.ahcpr.clin.ulcc/s/44531

[131] NPUAP, Statement on Pressure Ulcer Prevention, supra.

[132] Numerous resources are on the internet to assist nursing home staff in identifying and treating pressure ulcers. See, e.g., Taking Care of Pressure Sores, at http://depts.washington.edu/rehab/resources/flat-ps.pdf. Nursing homes are, therefore, without excuse for allowing pressure ulcer development.

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Statutes and regulations address both resident rights and quality of care. Breach of a duty defined by statute or regulation may be negligence per se. Due to the breadth of the Federal and State regulatory structure, where there is neglect, there is usually a potential negligence per se claim as well.

Negligence per se claims are recognized in virtually all jurisdictions, including Georgia and Tennessee.[133] These claims are described in the Restatement of the Law, Second, Torts, as follows:

> **§ 286 When Standard of Conduct Defined by Legislation or Regulation Will Be Adopted**
>
> The court may adopt as the standard of conduct of a reasonable man the requirements of a legislative enactment or an administrative regulation whose purpose is found to be exclusively or in part
>
> (a) to protect a class of persons which includes the one whose interest is invaded, and
>
> (b) to protect the particular interest which is invaded, and
>
> (c) to protect that interest against the kind of harm which has resulted, and
>
> (d) to protect that interest against the particular hazard from which the harm results.
>
> **§ 288B Effect of Violation**
>
> (1) The unexcused violation of a legislative enactment or an administrative regulation which is adopted by the court as defining the standard of conduct of a reasonable man, is negligence in itself.
>
> (2) The unexcused violation of an enactment or regulation which is not so adopted may be relevant evidence bearing on the issue of negligent conduct.

Virtually Courts reviewing nursing home legislation and regulations recognize that the

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[133] See T. Takacs, Elder Law Practice in Tennessee § 13-6(b)(1) (Lexis-Nexis 1998, 2002); and see C. Adams, Georgia Law of Torts § 3-6 (Thomson-West 2002).

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purpose of those statutes and regulations is to protect nursing home residents. Specifically, Georgia law requires that adequate and appropriate care, treatment and services be provided with reasonable care and skill, in compliance with all laws and regulations and respect for the resident's personal dignity and privacy. O.C.G.A. § 31-8-108(a)(1) and (4). Any person aggrieved because a long term care facility violates or fails to provide any right granted under this article shall have a cause of action against such facility for damages and such other relief as the court having jurisdiction of the action deems proper. O.C.G.A. § 31-8-126(a).[134] Residents are not required to exhaust administrative remedies before filing a law suit. Id. In addition to any other rights they may have,[135] residents have the following rights:

A.	OCGA § 31-8-104[136]	Each resident shall be given a written and oral explanation of his rights, grievance procedures and enforcement provisions provided for in this article at or before admission.
B.	O.C.G.A. § 31-8-108	Each resident shall receive care, treatment and services that are adequate and appropriate, which shall be provided with reasonable care and skill in compliance with all laws and regulations. Each resident has a right to choose physician and pharmacy.[137]
C.	OCGA § 31-8-111(3)	Each resident has rights as citizen including right to associate, meet or communicate with persons of choice.
D.	OCGA § 31-8-111(4)	Right to participate, inside and outside the facility, in social, family, religious and community group activities.

[134] Illinois has a similar statute. See Myers v. Heritage Enterprises, Inc., 773 N.E.2d 767 (Ill. App. 2002), discussing a claim brought under the Illinois Nursing Home Care Act.

[135] See 42 U.S.C. § 1396r(c) (1) through (8).

[136] The rights of Tennessee Nursing Home residents are similar and are codified at T.C.A. § 68-11-901 to 68-11-910.

[137] Interestingly, there is no right to choose one's psychologist. See Pruitt Corporation v. Strahley, 270 Ga. 430 (1999). There, the Court denied Strahley's claim for tortious intereference with a contract because "Pruitt and Strahley were parties to an interwoven contractual relationship in which each was responsible, and provided care, for the residents."

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E.	OCGA § 31-8-112(b)	Right to rise and retire at times of the resident's choice if the resident does not interfere with the rights of others.
F.	OCGA § 31-8-112(d)	Right to enter and leave the facility as the resident chooses.
G.	OCGA § 31-8-113(a)	Right to retain and use personal property including funds and clothing in resident's immediate living quarters as space permits.
H.	OCGA § 31-8-113(b)	Right to have personal property secured.
I.	OCGA § 31-8-114(1)	Right to privacy in the resident's room or portion of the room.
J.	OCGA § 31-8-114(2)	Right to a private room and to a personal sitter if the resident pays the cost of those services.
K.	OCGA § 31-8-114(3)	Right to private visits with spouse and to share a room with spouse.
L.	OCGA § 31-8-114(4)	Right to unimpeded private communication through mail, telephone or visitation, including right to receive unopened mail. See also Ga. Regs. § 290-5-8-.03(6).
M.	OCGA § 31-8-114(6) & (7)	Right to privacy in resident's medical, personal and bodily care program and to limit distribution of records.
N.	OCGA § 31-8-115(b)	Right to manage resident's own financial affairs.
O.	OCGA § 31-8-116	Right to be free from involuntary transfer except in specified circumstances.
P.	OCGA § 31-8-116(d) & (e)	Right to 30 days prior notice before involuntary transfer outside of the facility and to 15 days prior notice before involuntary intrafacility transfer.
Q.	OCGA § 31-8-116(g)	Right to be discharged upon resident's request or request of resident's guardian.
R.	OCGA § 31-8-116(h)	Right to treatment and care, rehabilitation services and assistance to prepare resident (if appropriate) to return home or to a less restrictive facility.
S.	OCGA § 31-8-116(i)	Right to return to facility following hospitalization.
T.	OCGA § 31-8-118(c)	Right to voice complaints and recommend changes in policies, procedures and services.
U.	OCGA § 31-8-119	Right to be free from coerced contributions to the facility.
V.	OCGA § 31-8-120	Right to visitation. "Visitors must be granted access to residents, who have the right to refuse or terminate any visit."

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W.	OCGA § 31-8-121	Right to form, attend and have space provided for resident councils.
X.	OCGA § 31-8-124	Right to file grievances and to have facility respond within three business days. Right to complain further if facility response is inadequate.

Nursing Home Reform Act and O.B.R.A. Regulations as Standard of Care:

Generally, there is no express or implied private right to "enforce" the Nursing Home Reform Act or the underlying O.B.R.A. regulations. See Brogdon et al. v. National Healthcare Corporation, 103 F. Supp.2d 1322, 1330-1332 (N.D. Ga. 2000).[138] This is true even though the Medicaid Act (the Nursing Home Reform Act) was enacted to benefit recipients and that the Act confers rights on the recipients. Id., at 1330. Absent evidence that Congress intended to create a private right of enforcement, the Court in Brogdon refused to imply one. That, however, does not end the inquiry. Left for determination was whether Plaintiffs could sue as third party beneficiaries under the contract between the nursing facility and Medicaid, Id., at 1334, and whether the O.B.R.A. regulations are relevant in determining the applicable standard of care. Id., at 1342-1343.[139] In Brogdon, the Court held that both of those issues turn on and would be resolved under State (Georgia) law. Other cases are as follows:

In Nichols v. St. Luke Center of Hyde Park, 800 F. Supp 1564 (S.D. Ohio 1992), a

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[138] See also Tinder v. Lewis County Nursing Home District, 207 F.Supp.2d 951 (E.D. Mo. 2001) (citing Brogdon).

[139] "The Legislature and courts of the State of Georgia are empowered to determine applicable professional standards of care in this State. If these standards of care reflect or incorporate federal Medicaid and Medicare participation requirements – or even the standard of care applied in a foreign country – neither the principle of federalism nor the principle that foreign governments cannot legislate for the citizens of the State of Georgia are offended. In other words, the content of the applicable standard of care is simply a matter of state law." Brogdon, 1342-43. Use of the statute in defining the applicable standard of care is consistent with the Restatement of the Law, Second, Torts, § 288B.

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nursing home resident filed suit after he was involuntarily discharged. When he could not find alternate nursing home placement, he brought an action for injunctive relief, asserting a private right of action to enforce the discharge rules under the O.B.R.A. regulations. The Court rejected his claim, finding that O.B.R.A. does not confer a private right of action and finding further, that the nursing home "substantially complied" with the Act's terms.[140]

In Satterwhite v. Reilly, 817 So.2d 407 (La. App. 2 Cir. 2002), the Court held that 42 C.F.R. 483.75 did not establish a standard of care with respect to a medical director. There, Plaintiff's case went to trial on the issue of whether Dr. Reilly acted negligently as the nursing home medical director.[141] The Plaintiff failed to prove the appropriate standard of care; mere citation to the federal regulations is insufficient.[142] See also Pack v. Crossroads, Inc., 53 S.W.3d 492 (Tex. App. 2001) (violation of non-penal administrative code does not support negligence per se claim); and Laurie v.Patton Home for the Friendless, 516 P.2d 76 (Or. 1973) (failure to charge negligence per se based on violation of city ordinance sufficient attendants to provide protection and care was not error).

Nonetheless, the Nursing Home Reform Act and the O.B.R.A. regulations may provide

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[140] In other words, this is an instance where bad facts make bad law.

[141] Specifically, Plaintiff alleged that Dr. Reilly failed to participate in any meetings, care plan reviews, review of minimum data sets, incident reports and failed to address the needs of the facility, thus violating 42 CFR 483.75(i). Plaintiff further alleged that Reilly failed to implement policies relating to fall prevention, proper hygiene, proper nutrition, hydration, infection control and medical attention.

[142] The Court reached the same result with respect to 42 CFR 483.40(a), noting that the Plaintiff offered no expert testimony to establish the standard of care. A similar issues appears in Makas v. Hillhaven, 589 F.Supp. 736 (M.D. N.C. 1984), where the "Plaintiff identified none of its witnesses as experts and represented to the Court that she did not intend to offer any expert testimony on the applicable standard of care [..., instead, contending] that the Nursing Home Patient's Bill of Rights established the standard of care." Query whether the result would have been different if a qualified expert testified that the O.B.R.A. regulations establish the standard of the care? See also Raney ex rel. Estate of Raney v. Ashford Hall, 2002 WL 14354 (Tex. App. Dallas 2002) (declining to find that a documented violation of state and federal statutes and regulations constitutes negligence per se).

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the applicable standard of care. In McMcain v. Beverly Health and Rehabilitation Services, Inc., 2002 WL 1565526 (E.D. Pa. July 15, 2002) (a pressure ulcer case), citing Sections 286 and 288 of the Restatement of Torts 2d, the Court held that an absence of a private right of action under O.B.R.A. does not end the inquiry. "A statute may still be used as the basis for a negligence per se claim when it is clear that, despite the absence of a private right of action, the policy of the statute will be furthered by such a claim because its purpose is to protect a particular group of individuals." Id., at *19.

Even if a violation of O.B.R.A. regulations is negligence per se, the Plaintiff must still prove causation. See e.g., Brown, supra, 225 Ga. App., at 6 (inadequate documentation of the medical chart did not cause injury); Long v. Brookside Manor, 885 S.W.2d 70 (Tenn. App. 1994) (negligent hiring action where employee assaulted nursing home resident); Rodriguez v. Care With Dignity Health Care, Inc., 2002 WL 5921 (Cal. App. 4 Dist. 2002) (failure to give negligence per se charge was not error because the jury found that such negligence did not cause the injury); Kohn v. American Housing Foundation, Inc., 178 F.R.D. 536, 542 fn 10 (D. Col. 1998).

6. Falls:

"The elderly are vulnerable to injury from falls. A fall prevention program should be implemented for persons who are at high risk of a fall or who have already fallen."[143]

The facility must ensure that (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. 42 CFR 483.25(h)

[143] Merck Manual, supra, p. 52.

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Falls are the leading cause of accidental death for persons over Sixty-Five.[144] They can result from intrinsic factors such as disease, or can be caused by extrinsic factors such as drugs or hazards. Disorders that increase the risk of falls include dementia, Parkinson's disease, impaired vision, ear conditions impacting balance, conditions causing peripheral neuropathy (e.g., diabetes mellitus), conditions impacting gait (e.g., arthritis, foot deformities), and serious systemic disorders that contribute to generalized weakness (e.g., cardiopulmonary disorders).[145] Drugs can contribute to falls by reducing alertness or impairing cerebral perfusion.[146] Environmental factors that can contribute to falls include poor lighting, carpets, rugs, unstable chairs, and wet, waxed slippery or shinny floors.[147]

Nursing homes should intervene to reduce or eliminate risks. The primary inquiries are should the nursing home have anticipated the risk of falls and what did it do to prevent them? In preventing them, the facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 42 CFR § 483.25(h). After the cause of the fall is identified, the nursing home should intervene to prevent a reoccurrence. For example, where drugs create a fall hazard, the nursing home should consider taking steps to have drug administration discontinued or to have dosage adjusted.[148] In each case, intervention begins with diagnosis, which is

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144 Merck Manual, supra, at 195. Falls can lead to fractures, which in turn lead to other complications such as functional impairment and pressure ulcers. Id., 197-198, 220.

145 Id., at 196.

146 Id., at 197.

147 Id., 197, 200-201.

148 Id., at 202.

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dependant on proper assessment.[149]

With regard to environmental hazards, handrails must be provided in hallways, stairways, ramps and in bathrooms near showers, tubs and toilets.[150] Floors must be smooth and level, scatter rugs, highly polished floors, and changes in floor level that pose a hazard are prohibited.[151] Nursing homes must be kept clean and free from debris.[152] Nursing homes must otherwise comply with all laws relating to the construction and maintenance of homes and the safety of patients therein.[153]

Among other steps the nursing home can take to prevent falls are:

1. Maintain regular toileting schedules;

2. Answer call lights promptly;

3. Provide proper fitting nonslip footwear;

4. Placing confused residents or those who attempt to walk without assistance (despite difficulty) closer to the nurses station;

5. Keep beds in low position with brakes locked;

6. Provide assistance devices to residents, either to assist them in ambulating or to remind them to request assistance;

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[149] Id., at 176, 183, 188, 198, 206. Technically, syncope related events are not "falls." Id., at 195.

[150] Ga. Regs. § 290-5-8-.13(3), (4) and (7). See also Ga. Regs. § 290-5-8-.18(10(f) (grabs rails must be near all bathtubs, showers and water closets intended for patient use); .18(g) (stairs and landing shall have nonslip surface); .18(l) (ramps shall have a maximum slope of 10%); .18(m) (ramps shall have nonslip finish); .18(n) (handrails shall be provided on each side of all patient corridors, stairsways and ramps).

[151] Ga. Regs. § 290-5-8-.13(4) and (6). Bathroom floors must be made from nonslip material. Ga. Regs. § 290-5-8-.13(7).

[152] Ga. Regs. § 290-5-8-.14(3).

[153] Ga. Regs § 290-5-8-20(1).

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7. Reduce or eliminate restraints that have the potential to form traps.[154]

In Davis v. First Healthcare Corporation, 234 Ga. App. 744 (1998), relatives of a nursing home resident sued the nursing home after the unrestrained resident fell from bed, suffering an injury. The medical chart included a physician's order calling for restraints. Based on that record, an issue of fact existed concerning whether the nursing home was negligent and Defendant's motion for summary judgment was denied.

In Pye v. Taylor & Bird, Inc., 216 Ga. App. 814 (1995), a resident fell and broke her arm after leaving a room for soiled laundry. Moisture was found on her shoes. The nursing home moved for summary judgment alleging that Mrs. Pye was told during her initial tour of the home that the laundry room was "off limits" and that she should not have been there. The Court analyzed the case as a traditional slip and fall case (who had superior knowledge) and denied the nursing home's motion finding: "There is no evidence of record that warning signs were posted outside the door to the room, or that the door had a lock on it. Moreover, Mrs. Pye's apparent unobserved entry into the room, itself, presents an issue of fact as to whether defendant even attempted to monitor the room to keep residents out. Furthermore, even though Coley and Mincey both testified that they believed that Mrs. Pye understood that she was not to enter the soil utility room, a factual issue remains regarding whether Mrs. Pye, as an elderly resident, was capable of understanding any dangers associated with entering the room."

Another helpful guide, prepared by nursing home litigator Leslie Clement, is a chart for

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[154] K. Anderson, Medical Issues in Nursing Home Litigation 7-8, in Nursing Home Negligence [I]: Asserting Claims & Defending Nursing Homes (PESI 1999).

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use in evaluating the nursing home care plan in fall cases. See L. Clements, Evaluating the Nursing Home Care Plan in a Fall Case, 1 The Advocate 6 (ATLA Nursing Home Litigation Group 2001). There, Clement cites various factors causing falls and how they should be assessed. See also Handbook of Geriatric Nursing Care, supra 263-269.

7. Improper Administration of Medication:

> The facility must ensure that it is free of medication error rates of five percent or greater; and residents are free of any significant medication errors. 42 CFR 483.25(m).

Medications must be administered consistent with physician orders. The administration of an improper medication, or improper administration of the proper medication, can lead to severe injury or death. A case involving improper administration of medicine may be one where *res ipsa loquitor* applies.

Residents and their family members may make inquiry concerning the medications administered. Each resident shall, upon his request, be informed of the identity, purpose, and possible reactions to each drug to be administered. O.C.G.A. § 31-8-110(d).

Federal regulations also prohibit the administration of unnecessary drugs. 42 CFR 483.25(l)(1)[155]. Further, the facility must ensure that residents who have not used antipsychotic drugs are not given them unless they are necessary to treat a specific diagnosed condition. 42 CFR 483.25(l)(2). In this regard, any new administration of Haldol or similar medication should

[155] An unnecessary drug is any drug when used: (i) in excessive dose (including duplicate drug therapy); or (ii) for excessive duration; or (iii) without adequate monitoring; or (iv) without adequate indications for its use; or (v) in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) any combinations of the reasons above. 42 CFR 483.20(l)(1).

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be carefully scrutinized.

8. Physical or Emotional Abuse:

> The resident has the right to be free from verbal, sexual, physical and mental abuse. 42 CFR 483.13(b). The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion. 42 CFR 483.13(c). The facility must not employ persons who have been found guilty of abuse. 42 CFR 483.13(c)(1)(ii).

All nursing personnel and employees having contact with patients shall receive social service orientation and in-service training toward understanding emotional problems and social needs of patients. Ga. Regs., 290-5-8-.07(3).

9. Elopement:

"Elopement is the ability of the resident not deemed capable of self-preservation to successfully depart the building unsupervised and undetected and to thereby enter harm's way."[156] Claims often center of injury sustained after the resident exits the facility, which would not have occurred if the resident was kept safe. Examples are injuries where the resident is hit by a vehicle or suffers from environmental factors such as hypothermia. In one case handled by Jay Clements, a resident with a history of elopement was kept safe in every way except one. Staff took their smoke breaks on the loading dock and, for their own convenience, kept the entrance to the loading dock unlocked. The resident wandered through the door and fell, head first, off of the loading dock, suffering a fatal injury.

In Chandler v. Haralson Nursing and Rehabilitation Center et al., State Court of Fulton County, CA 00VS007386F, a resident known to be at risk was injured when her wheel chair

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[156] B. Arbeit, Elopements of Cognitively Impaired Residents: Case Analysis and Preparation, A-2, in Litigating Nursing Home Cases (ATLA March 17-18, 2000).

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rolled out of a "secured" front door. She fell, struck her head and died. The home relied on a "Wanderguard" system that, in the past, had proven itself unreliable. The resident's survivors brought suit alleging that the home was negligent in allowing the resident to exit the facility and suffer injury.

10. Improper Use of Restraints:

Federal regulations provide: "The resident has the right to be free from any physical or chemical restraints imposed for the purpose of discipline or convenience, and not required to treat the resident's medical symptoms." 42 CFR 483.13(a). This does not mean that a no-restraint policy is appropriate. Instead, it means that restrains must have a medical purpose when they are used. For example, where a wheel-chair bound resident is evaluated as being at high risk for falls, a lap belt might be appropriate. Alternatively, where a resident is not at risk for falls, bed rails may constitute restraints and may be inappropriate.

Georgia law provides that:

> (a) Each resident shall be free from actual or threatened physical restraints, isolation, or restrictions on mobility within or outside the facility grounds, including the use of drugs to limit mobility, except to the minimum extent necessary to protect the resident from immediate injury to the resident or to others. In no event shall restraints, restrictions, or isolation be used for punishment, incentive, behavior conditioning or modification, or for the convenience of the facility.
>
> (b) Restraints, restrictions, or isolation shall be used only subject to the following conditions:
>
> (1) Prior to authorizing restraints, restrictions, or isolation, the attending physician shall make a personal examination and individualized determination of the need to use such restraints, restriction, or isolation on that resident and shall specify a reasonable time for such use. No restraint, restriction, or isolation shall be used by the facility longer than 65 days for intermediate care residents and longer than 35 days for skilled nursing residents, except by reorder of the attending physician after personal examination of the resident. Irrespective of such time period specified, restraints, restrictions, or isolation shall not be used beyond the period of actual need;
>
> (2) In an emergency situation, restraints, restrictions, or isolation shall be authorized

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> by the person in charge only to protect the resident from immediate injury to the resident or others and shall not be continued for more than 12 hours after the onset of the emergency without personal examination and authorization by the attending physician;
>
> (3) The resident and a person designated by the resident, if any, shall be informed immediately of the need for the use of restraint, restriction, or isolation, the reasons for such use, and the time the physician has specified for such use. Such information shall be recorded in the resident's file;
>
> (4) A restrained or isolated resident shall be monitored by the staff at least every hour and released and exercised at least every two hours, except during normal sleeping hours; and
>
> (5) When a restraint, restriction, or isolation is used under this Code section, the resident shall retain all rights enumerated in this article.

Restraint and/or forcible seclusion of a patient will be utilized only on a signed order of a physician, except in emergency and then only until the advice of a physician can be obtained. Ga. Regs § 290-5-8-.10(9).

11. Breach of Contract:

The nursing home admission agreement may create a contractual duty of care in addition to other rights residents have under statute and regulations, and may assist in establishing the applicable standard of care.[157] Thus, in addition to tort claims, you should consider pleading a breach of contract claim. E.g., Wolfe v. Virusky, 306 F. Supp. 519, 520 (S.D. Ga. 1969). By undertaking a resident's care, the health care provider implicitly warrants that she possesses the required skill to treat the resident and that she will exercise ordinary skill and care. Id.; see also Ga. Regs § 290-5-8.05(4); Tn. Regs. § 1200-8-11-.05(1). It may be possible for the care giver to maintain a breach of contract action, separate from the resident's tort action, if the care giver

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[157] T. Takacs, Elder Law Practice in Tennessee § 13-6(b)(1) (Lexis-Nexis 1998, 2002). See Associated Health Systems, Inc. v. Jones, 185 Ga. App. 798 (1988) (stating that nursing home owed resident a contractual duty of care).

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entered into the agreement for health care services. See Scott v. Simpson, 46 Ga. App. 479 (1933); Fisher v. Toombs County Nursing Home, 223 Ga. App. 842 (1996).[158] The two year statute of limitations applies regardless of whether the claim sounds in tort or contract.[159]

Do not overlook claims as a third-party beneficiary of contracts between CMS or the State and the facility. Georgia law provides that all payments made, regardless of payee, are for the benefit of the resident. O.C.G.A. § 31-8-115(a). Thus, the Court's analysis in Brogdon, supra, that State law controls third-party beneficiary claims, may provide the resident with another theory of liability.[160]

Other Contract Issues:

A. Arbitration:

i. In Integrated Health Services of Green Briar, Inc. v. Lopez-Silvero, 827 So.2d 338 (Fla. App., 3rd Dist. 2002), the nursing home filed a motion to compel arbitration. The trial court denied the motion after finding that the nursing home failed to sign the arbitration agreement. That decision was reversed on appeal because the parties "acted as if they had a valid contract."

ii. In Community Care of America of Alabama, Inc. v. Davis, 2002 WL 31045217 (Ala. 2002), an arbitration clause in the admission

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[158] In Fisher, the Court found that the resident's wife, as responsible party who signed the admissions agreement, had standing under O.C.G.A. § 9-2-20(a) to maintain a claim against the nursing home. Her husband was discharged into the care of his son from a prior marriage without notice to her. Although she was not the beneficiary of the contract, as a promisor, the Court found that the nursing home had an implied contractual duty to notify her prior to discharging her husband, holding: "an implied term in an agreement exists where it is reasonable and necessary to effect the full purpose of the contract and is so clearly within the contemplation of the parties that they deemed it unnecessary to state." Query whether there is likewise an implied *contractual* duty to comply with State and Federal quality of care and dignity regulations?

[159] Royal & Alexander, supra, § 2-4.

[160] For example, in Doe v. Westfall Health Care Center, Inc., 2002 WL 31888128 (NYAP 4 Dept. 2002), a mother brought suit, individually and on behalf of her daughter's estate after her daughter was raped in a nursing home. The Court dismissed the claims brought in the mother's individual capacity.

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agreement was not enforced because the nursing home was not qualified to do business in Alabama at the time the contract was signed, which rendered all of its agreements unenforceable. Obviously, this is not the preferred method of attacking an arbitration agreement, but it demonstrates creativity from the Plaintiff bar.

iii. In Flaum v. Superior Court of Los Angeles County, 2002 WL 31852905 (Cal. App. 2nd Dist. 2002), a motion to compel arbitration was granted as to the resident's claims, but denied, citing Buckner v. Tamarin, 98 Cal. App. 4th 140 (Ca. App. 2nd Dist. 2002), as to the heirs' claims since the heirs were not parties to the arbitration agreement. A different result was reached, however, in Pararigan v. Libby Care Center, Inc., 120 Cal. Reptr. 2nd 892 (Cal. App. 2nd Dist. 2002), where a resident's relative, without a durable power of attorney, signed the arbitration agreement. The Court affirmed an order denying a motion to compel arbitration because the alleged agent lacked authority to consent to arbitration on the resident's behalf.

B. Admission of Nursing Home Agreement as evidence at Trial.

i. In Gates v. Sells Rest Home, Inc., 57 S.W.3d 391 (Mo. App. S.D. 2001), the trial court admitted a nursing home agreement as evidence at trial even though it included an invalid exculpatory clause. No limiting instruction was given. On appeal, the Court held: "the [trial] court erred by allowing the facility agreement (or any of its provisions) into evidence."

C. Illegal Contract Provisions.

i. Nursing home admission agreements often include terms that are illegal, such as requiring the resident's attorney-in-fact to guarantee payment of nursing home charges. "Federal regulation 42 C.F.R. § 483.12(d)(3)(ii) provides that a facility may not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation or other consideration as a precondition of admission, expedited admission or continued stay in the facility." H. Tettlebaum, The Long Term Care Hanbook: Regulatory, Operational & Financial Guideposts § 4-2(d) (American Health Lawyers Association 2000; 2nd

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Edition).[161] In 1994, Bet Tzedek Legal Services reviewed 65 randomly selected admission agreements in the Los Angeles area and found that 67.7% of them included this illegal provision. See Bet Tzedek Legal Services, If Only I Had Known: Misrepresentations By Nursing Homes Which Deprive Residents of Legal Protection (1998) at 5 (available at www.bettzedek.org). Virtually all agreements covered included some other illegal term. Id.[162] *Query* whether inclusion of illegal terms renders the remainder of the agreement (such as an arbitration clause) void, voidable, or whether it would be evidence that the facility routinely disregards the rights of its residents.

ii. In Slovik v. Prime Healthcare Corporation, 2002 WL 1350448 (Ala. App. 2002), a nursing home sued the responsible party for payment of a $5,282 balance due on the resident's stay. The nursing home admitted that Slovik signed as "Responsible Party." Thereafter, the Court held that there was no contract between the nursing home and Solvik.

Other Claims and Issues

Attorneys Fees: "[W]here the plaintiff has specially pleaded and has made prayer [for expenses of litigation, including attorney's fees] and where the defendant has acted in bad faith, has been stubbornly litigious, or has caused the plaintiff unnecessary trouble and expense, the jury may allow them." O.C.G.A. § 13-6-11.

Prejudgment Interest: The Plaintiff may demand prejudgment interest on unliquidated claims, but must follow the statutory procedure outlined in O.C.G.A. § 51-12-14 to do so. If the demand is properly made, and if the Plaintiff recovers at least the amount demanded, then the twelve percent (12%) interest runs on the demand amount from the thirtieth day following

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[161] This American Health Lawyers Association book is written for lawyers who represent nursing homes. Obviously, in light of AHLA's recognition that third party guarantees are illegal, nursing homes including them in their admission agreements are without excuse.

[162] The Bet Tzedek study reviews numerous illegal, but common provisions found in nursing home admissions agreements and includes a "Model" admissions agreement.

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mailing through the date of judgment. The Defendant can stop the interest clock by making a written offer to pay the demand amount plus interest through the notice date. The statute should be reviewed for technical compliance before making any offer or response.

Punitive Damages: "Punitive damages may be awarded only in such tort actions in which it is proven by *clear and convincing evidence* that the defendant's actions showed *willful misconduct, malice, fraud, wantonness, oppression, or that entire want of care which would raise the presumption of conscious indifference to consequences*." O.C.G.A. § 51-12-5.1(b).

Elder Abuse and Protection Statutes: Most States now have statutes providing specific protection to the elderly. Violation of these statutes by a nursing home or staff member will likely serve as a basis for punitive damages and may, in certain cases, provide a separate basis for an attorney's fee or other related claim. See e.g., O.C.G.A. § 16-5-100 (Cruelty to a person 65 years of age or older); O.C.G.A. § 30-5-1 through 30-5-8 (Protection of Disabled Adults and Elder Persons).

Falsification of Records: Reports of falsified records are common in nursing home cases. You will not detect chart falsification absent careful investigation. You should carefully analyze the chart, looking for discrepancies. You should determine whether the chart matches reality (e.g., the resident is malnourished while the chart says "Dad" ate 100% of every meal). You should also track down witnesses who can tell you whether the nursing home routinely held "charting parties" or otherwise engaged in tactics to falsify the chart. In Georgia, falsification of medical records is a misdemeanor and, as such, may provide an independent basis for punitive damages and attorney's fees. See O.C.G.A. § 16-10-94.1(b). Record falsification may also constitute a violation of statutes requiring nursing home staff to report elder abuse. See

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O.C.G.A.§ 31-8-80 et seq.

Insurance: In Georgia, a plaintiff is entitled to pre-suit disclosure concerning the extent of insurance. O.C.G.A. § 33-3-28. The rule is different in other states. For example, in Tennessee, disclosure concerning insurance is not required.

Class Certification: In Kohn v. American Housing Foundation, Inc., 178 F.R.D. 536 (D. Col. 1998), the Plaintiffs filed a motion for class certification. The motion was denied. The Court analyzed the case consistent with F.R.C.P. Rule 23, finding that the Plaintiff must show why (1) the class is so numerous that joinder of all parties is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative class are typical of the claims or defenses of the class, and (4) the representatives will fairly and adequately represent the class. Analysis broke down on the issue of causation and damages since each class Plaintiff would, individually, be required to demonstrate that he or she suffered harm due to the Defendants' negligence. A similar analysis found was used in the Brogdon case.

Informal and Formal Discovery (or, What You Need to Tell the Story)

You cannot tell your client's story without facts. Facts are developed through informal and formal discovery. All discovery should follow a plan, and should be developed to support your theory of the case.

Depositions: Identifying Persons Who Will Tell The Story

It goes without saying that the lawyer rarely gets to testify. Therefore, you need to identify witnesses who can tell your client's story. On your side of the ball, if your resident is alive, he or she may be your first witness. Friends, family and friendly health care providers

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should also be interviewed. Although you rarely depose your own witness, you will need to prepare them for deposition. Be certain your witness understands that you want the truth and only the truth, but that you want the WHOLE truth. Often that means working through the details, perhaps reviewing the resident's nursing home record, as they recall events.

You will use expert witnesses to establish the standard of care and proof of its breach. Experts may need to testify concerning the purpose of regulations so demonstrate why its breach is causally related to your client's injury.[163]

On the other side of the ball, you need to hear from witnesses who will testify for the defense. Learn their story early so you have time to analyze it and determine whether the nursing home witnesses are telling the truth. You should depose everyone with responsibility for assessment, care planning, prevention and treatment of the injury your client sustained; thus, your client's claim will guide you in determining who to depose. Consider videotaping all depositions.[164] Among the persons you should depose are:

1. the Administrator,[165]
2. the Director of Nursing,[166]
3. the wound care staff if the case involves pressure ulcers,
4. the dietary staff if it involves malnutrition or dehydration,

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[163] R. Balisok, Nursing Home Litigation, in The Best of NAELA Serios: Nursing Homes, at 4 (NAELA 2000).

[164] Turnover in nursing homes is notoriously high. You cannot assume you will be able to locate CNAs at the time trial.

[165] 42 CFR 483.75(d)(2)

[166] 42 CFR 483.30(b)(2)

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5. certified nursing assistants, and potentially anyone else who "laid hands on" your client.[167]

Documents You Will Need To Prove Your Case

You should request copies of all medical records from various health care providers who rendered care and treatment to the nursing home resident.[168] Among those documents you should collect and consult, either before filing suit[169] or as part of discovery, are:

(A) Nursing Home Resident Records and Medical Records

The nursing home record should clearly chart the resident's condition at the time of admission, through discharge. It should, because "the nursing process is a systematic method of planning and providing care to clients."[170] Documentation should reflect what care was provided and "is a communication method that ... clearly outlines all important information regarding the client. ... If it is not documented in the client's record, it did not occur "[171]

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[167] Georgia's nurse aide registry is at: http://www2.state.ga.us/Departments/DHR/ORS/nar-home.htm.

[168] R. Krisztal, Investigation and Pretrial Considerations in the Civil Prosecution of a Nursing Home Case for Personal Injury and Other Damages, in Nursing Home Litigation: Investigation and Case Preparation 361, 365 (Lawyers & Judges Publishing Co., Inc. 1999). However, nursing home records are often voluminous and judgment must be exercised when requesting nursing home records beyond the applicable statute of limitations.

[169] One prominent litigator cautions that "Due to the risk that a facility might falsify records, an attorney should generally not request documents from the facility until a complaint regarding the facility's conduct has been made to the appropriate government enforcement agency, and the agency has completed its investigation." E. Carlson, Litigating Against Long Term Care Facilities § 10.03[1], in Long Term Care Advocacy (Lexis-Nexis 1999, 2002). Generally this "rule" which may delay securing a copy of the nursing home record should be tempered with judgment. At some point, you simply must secure the record if litigation is to be filed. For example, in Georgia, you cannot file suit until you secure an expert affidavit. O.C.G.A. § 9-11-9.1. If a statute of limitations is near, you need sufficient information to enable an expert to review the case and it may be time to "damn the torpedoes, full speed ahead."

[170] L. White, Documentation and the Nursing Process, 3 (Thomson/Delmar Learning 2003).

[171] Id., at 75 and 80. Each home shall maintain a complete medical record on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given. Ga. Regs. § 290-5-8-.11(1). Certainly, it is difficult for the nursing home to argue it provided particular treatment in the absence

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The standard medical chart should include the following:[172]

1. Admissions information:[173]

   a. Face Sheet/Transfer Forms.

      i. The face sheet should include the resident's vital information including legal name, age, next of kin, treating physician, scope of treatment and other demographic data. In Georgia, a standard form, Form DMA-6, is completed on all nursing home residents.[174] Unless the nursing home has a separate face sheet, this document may serve that function.

   b. Advanced directives

      i. You need to be aware of the existence of any advanced directive, such as a Living Will or Do Not Resuscitate (DNR) order. In death cases, nursing homes will often attempt to use them against the Plaintiff, contending that they were not permitted to take life saving measures or will attempt to minimize damages by having the family agree they knew the resident was on death's door. These documents may also identify the resident's wishes regarding tube feeding, pain management, or other means that could have been used to extend the resident's life.

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of charting. This is amplified where the nursing home's policy & procedure manual requires regular or daily charting.

[172] This standard medical chart form is adapted from on appearing in J. Britt, Geriatric Care in Skilled Nursing Facilities and Identification of Medical Issues: Nursing Perspective, in Nursing Home Negligence Conference II (PESI 2000). Mrs. Britt graciously reviewed this list and provided comments on it, many of which have been incorporated. The entire chart should be reviewed by the nursing expert for the period in question and should cross-checked for consistency. The nursing home clinical chart must be complete, accurately documented, readily accessible and systematically organized. 42 CFR 483.75(l)(1).

[173] Ga. Regs. § 290-5-8-11(1)(a) and (b).

[174] Form DMA-6 , a physician's recommendation for nursing home placement, must be completed if the resident will be on Medicaid. "A doctor must fill out a form called a DMA-6 and submit it to the Georgia Medical Care Foundation for evaluation. This is a fairly simple procedure and the initial determination by the Georgia Medical Care Foundation can be done over the phone." Atlanta Legal Aid Society, Basics of Medicaid, at http://www.law.emory.edu/PI/ALAS/medicaid.htm

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ii. A legal nurse consultant will want to know the family's position concerning what care should have been given following trauma, or during a period of incpacity.

c. Hospital Discharge.

i. Transfer forms: Describe the resident's condition and diagnosis at the time of transfer to a nursing facility. If possible, get both the hospital transfer form and any ambulance reports as they may include information describing the resident's condition at a fixed time.

ii. Discharge summaries: likewise, can provide third-party base-line information regarding the elder's health as of the discharge date. Discharge forms may include prognosis and orders for future treatment. The discharge summary may include entries from other professionals such as psychologists, therapists, etc. The discharge summary should be compared with the MDS and Care Plan to determine whether the resident's needs where properly assessed and treated.

d. Admission Order[175]

i. "At the time each resident is admitted, the facility must have physician orders for the resident's immediate care." 42 CFR 483.20(a).

ii. Admission orders may indicate what medications the resident should receive, as well as information concerning whether restraints should be used or whether other special treatment should be given.

e. Facility Admission Forms as signed by resident or representative.

i. Required Notices: At the time of admission, the facility must provide notices including, information concerning the resident's rights, all rules governing resident conduct and responsibilities, information regarding Medicaid eligibility, charges, resident advocacy programs (State Ombudsman

[175] Ga. Regs. § 290-5-8-.10(1) and (2).

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program), information concerning how to file grievances, information telling the resident how to contact his/her physician. 42 CFR § 483.10.

ii. Representations made by the facility may establish a self-imposed standard of care higher than OBRA.

f. Facility Admission Agreement[176]

i. The admission agreement states what care and services the facility agrees to provide to the resident. For Medicare and Medicaid residents, the facility must provide without additional charge care and services covered under the applicable program. 42 CFR 483.10(c).

ii. As with the Care Plan, infra, the facility admission agreement may provide a separate basis for a claim against the nursing home. Often, representations are made in the agreement that appropriate nursing care will be provided.

iii. Some nursing homes have attempted to contractually limit the scope of the care provided. For example, at least one facility has included a provision in its agreement limiting the nursing staff hours to 2 per day. This is inconsistent with Federal and State law and demonstrates the facility's failure to comply with the law.

iv. Often, nursing home admission agreements now include an arbitration clause. State law will control whether the arbitration clause is enforceable.

v. Often the facility will violate OBRA by requiring a third party guaranty of payment. See 42 CFR 483.12(d)(2).

g. Consent Forms.

i. Nursing home residents retain their right to receive information concerning treatment and to choose the direction their treatment will go, or to refuse treatment. Thus, there is typically a consent to treatment form in the

[176] Written admission agreement required. Tn. Regs. § 1200-8-11-.05(2)(b).

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file. This document, like the advance directive, may provide information about the treatment preferences of the resident.

2. History and Physical Examination.[177]

   a. Unless the hospital documentation includes a history and physical examination performed within the past 24 hours, a history and physical examination should be performed within 72 hours following admission to the nursing home.[178] A nurse consultant we use states that a history and physical examination within 7 days prior to admission is sufficient but that, absent one, the history and physical examination must take place within 48 hours after admission.

   b. During each visit, the physician must review the resident's total program of care, including medications and treatments, must write, sign and date progress notes and must sign and date all orders. 42 CFR 483.40(b).

3. Assessment/Minimum Data Set (MDS).[179]

   a. Based on information taken during the admission process, an interim care plan should be developed immediately.[180] "The interim care plan is typically based on physician orders and the nursing admission assessment, and guides all resident care until the interdisciplinary care plan is developed.[181]

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[177] Ga. Regs. § 290-5-8-.11(1)(g).

[178] "The attending physician or licensed independent practitioner (LIP) performs a *medical assessment*, including a medical history and physical examination, within a time frame appropriate to the resident's condition. This time frame must not exceed 24 hours before admission or within 72 hours after admission." Intent of Standard PE.1.3.1 in 2000-2001 Standards for Long Term Care (JCAHO 2000) (emphasis in original).

[179] MDS forms are on the CMS website at http://cms.hhs.gov/medicaid/mds20/default.asp.

[180] See TX.1.1.1 and Statement of Intent, in 2000-2001 Standards for Long Term Care (JCAHO 2000).

[181] Id.

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b. Typically, the MDS is the primary assessment document.[182]

c. The MDS is a core set of screening and assessment elements that forms the foundation of the comprehensive assessment for all residents in Medicare or Medicaid Certified facilities. State Operations Manual § 4152.2.

d. As discussed above, each resident must be assessed with fourteen days after admission, and must be re-assessed at regular intervals thereafter, and after any significant change in condition.[183]

e. The assessment should be compared with other records showing the resident's true condition to determine whether the nursing home resident was injured due to a failure to provide a necessary treatment or to show that the nursing home had notice of the resident's condition where a necessary treatment was omitted. The key inquiry is "Were risks identified?"

4. Resident Assessment Protocols (RAPS) or other assessment documentation.[184]

a. The MDS alone does not provide a complete assessment. Instead, it is used as a preliminary screening to identify potential resident problems, strengths and preferences.[185] There are 18 RAPs in version 2.0 of the Resident Assessment Instrument. The 18 RAPs are as follows: delirium, cognitive Loss/Dementia, visual function, communication, ADL Function/Rehabilitation, urinary continence and indwelling catheter, psychosocial well-being, mood state, behavior symptoms, activities, falls, nutritional status, feeding tubes, dehydration/fluid maintenance, dental care, pressure ulcers, psychotropic drug use, physical restraints.

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[182] 42 CFR 483.315.

[183] 42 CFR 483.20(b). The facility must periodically review the resident's status so that decisions are made appropriately and timely. Reassessments are performed according to the course of the resident's treatment, according to time intervals specified by the organization, when the resident's physical, psychological functional or nutritional status changes significantly, or according to legal or regulatory requirements. See PE.3 and Statement of Intent, in 2000-2001 Standards for Long Term Care (JCAHO 2000).

[184] See CMS, Chapter 4: Procedures for Completing the Resident Assessment Protocols (RAPs) and Linking The Assessment to the Care Plan, at http://cms.hhs.gov/medicaid/mds20/rai702ch4.pdf.

[185] Id.

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b. Failure to complete a RAP where it is triggered[186] may lead in an inaccurate or incomplete assessment and, to inadequate care.

5. Care plans, and all documentation showing modifications or implementation of the plan.

a. A care planning process must be in place designed to ensure that the care and treatment planning is systematic and comprehensive.[187] Care planning is individualized to address the resident's problems, needs, and severity of condition, impairment, disability, or disease.[188]

b. Assuming the resident's condition was properly assessed, the care plan is the primary document showing what treatment the resident should have received. It serves as a guide in reviewing the remainder of the nursing home chart. For example, if the care plan calls for repositioning every two hours due to immobility, when the resident develops pressure ulcers and the record fails to document repositioning, you are able to show a breach of the standard of care coupled with knowledge on the part of the nursing home concerning what treatment was required. Obviously, this is helpful when you must show that a negative outcome was foreseeable.

c. 42 CFR Part 483 generally makes the nursing facility responsible for preventing negative outcomes unless they are unavoidable. If the nursing home fails to account for know risks and provide appropriate treatment, it will be unable to demonstrate that a negative outcome was unavoidable.

d. As stated elsewhere, failure to abide by the care plan is itself actionable. The essence of the care plan is that it must be designed to meet the resident's needs. 42 CFR 483.20(k). "The plan of care is precisely the consideration sought by the caregiver client when contracting for the services of the nursing home, which is why [it

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[186] Specific resident responses to MDS elements "trigger" the varioud RAPs. See State Operations Manual, § 4145.2 and see Resident Assessment Instrument for Long Term Care Facilities, Appendix R to State Operations Manual.

[187] TX.1, in 2000-2001 Standards for Long Term Care (JCAHO 2000).

[188] TX.1.2, in 2000-2001 Standards for Long Term Care (JCAHO 2000).

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is] the Contract." See H.K. Bennett, The Care Plan is the Contract: So Negotiate It Well, in The Best Of NAELA Series: Nursing Homes, at 5-6 (NAELA 2000).[189] See also O.C.G.A. § 51-1-8.

e. The structure of the care plan must be interdisciplinary.[190] Thus, if the nursing home fails to involve, for example, a dietary services as they develop the plan, then one could argue that the standard of care was breached when the resident suffers from malnutrition.

f. The care plan is "interwoven" with quality of care issues such as fall prevention, etc.[191]

g. The medical director is responsible for implementation of resident care policies and coordination of medical care in the facility. 42 CFR 483.75(i).[192]

6. Physician's Progress Notes.

a. The progress notes should track continuing assessment of the resident and the effectiveness of the treatment/care plan.

b. See Physician orders, supra.

7. Physician's Orders.[193]

a. Physician's orders may be verbal, written or delivered by telephone. Many nursing home records separate document telephone orders.

b. Physician/s orders should be compared with nursing notes and should correlate with medication records and physician progress notes. Orders are primarily directed to the nursing staff, but may

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[189] Mr. Bennett's article is an excellent tool for Elder Law attorneys seeking guidance on how to insure that client-residents receive quality care.

[190] TX.1.3, in 2000-2001 Standards for Long Term Care (JCAHO 2000).

[191] Arbeit, The Administrator and Nursing Home Liability Issues, in Nursing Home Litigation: Investigation and Case Preparation, at 134 (Lawyers & Judges Publishing 1999).

[192] See also Guide to Surveyors, supra, Tag F501.

[193] 42 CFR § 483.20(a); Ga. Regs. § 290-5-8-.10(4).

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also be directed to other specialists such as dieticians. Orders should address specific aspects of the care plan, such as the use of restraints, repositioning and medication dosage and timing. Orders may request that certain procedures or test be performed and, if so, there should be a correlating record showing that the procedure was performed or the test was completed.

c. The resident "must be seen" by his/her physician at least once every 30 days for the first 90 days following admission and at least once every 60 days thereafter. "Must be seen" means "the physician must make actual face-to-face contact with the resident. 42 CFR § 483.40(c); and see F Tag 387.

8. Nurses Notes.[194]

a. For Medicare residents, there should be a complete assessment note during each 24 hour period.

b. For Medicaid intermediate care residents or Medicaid skilled care residents, at a minimum, there should be a regular assessment summary, either weekly or monthly.

c. At a minimum, nursing staff should "document all assessment findings according to your facility's policy."[195]

d. Some facilities use different color inks for different shifts.

9. Weight Sheets.

a. Residents must be weighed monthly, or more often if appropriate to their needs. At least one nurse consultant states residents weighing under 100 pounds should be weighed weekly. A resident must not lose more than 5% of body weight during one month, 7% in 3 months, or 10% in 6 months. See F Tag 326; and see TX.5.1, in 2000-2001 Standards for Long Term Care (JCAHO 2000).

b. "The nursing home nurse is responsible for ensuring that the resident is weighed at prescribed intervals and that weight loss is detected and reported to the physician." P. Iyer, Nursing Liability

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194 Ga. Regs. § 290-5-8-.11(j).

195 Handbook of Geriatric Nursing Care, supra, at 84.

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Issues, at 188, in Nursing Home Litigation: Investigation and Case Preparation (Lawyers & Judges Publishing Co. 1999).

c. Residents should be weighed weekly during the first 4 weeks following an admission and, if weight is stable, monthly thereafter. See Altered Nutritional Status: Clinical Practice Guidelines, at 26 (AMDA 2001).

10. ADL Flow Sheets (Nursing Assistant Flow Sheets)

a. These are the primary records completed by CNAs. They may indicate an absence of care, which is helpful in showing that a negative outcome was not unavoidable. ADLs show what "routine care" means at the facility.

b. ADLs may indicate that the level of resident activity, such as ambulation and appetite. They may note resident complaints, wandering behavior, etc.

c. These documents may record family presence, or may support family claims.

d. ADLs may document different levels of care by different shifts, demonstrating a staffing issue, for example, on third shift or weekends.

11. Restorative Nursing Sheets.

a. Restorative activities promote independence in feeding, dressing, bathing, toileting, continence, and moving and position.[196]

b. These records are typically completed by the CNA staff.

12. Intake and Output Flow Sheets.

a. I/O flow sheets record how much food and fluid the resident has taken in and the amount of waste. These records are critical in evaluating dehydration and malnutrition cases.

b. Intake and output should be monitored for any resident with

[196] How to be a Nurse Assistant, supra, at 291.

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Altered Nutritional Status.

c. Unless charted in ADL Flow Sheets, I/O Flow sheets should document patient willingness to eat, supplements given. An absence of output may be diagnostic of a gastric obstruction.

13. Physical Therapy records[197]

a. PT records may document a resident ability to ambulate, or the level of restorative treatment where there is impairment. They should be given special attention where there is a restraint, or a pressure ulcer.

14. Occupational Therapy records

15. Speech Therapy records.

a. Speech therapy records document treatment for any swallowing disorder such as dysphagia.

16. Activities[198]

a. Activity records are an important part of assessing psycho-social well-being. They may indicate the level of attention given to a resident suffering from depression, or may indicate a resident's willingness, or lack of willingness, to participate in therapy programs.

17. Social Services[199]

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[197] Ga. Regs. § 290-5-8-.09(2). The physical therapy record must include referral, diagnosis, precautions, initial physical therapy evaluation treatment plan and objectives, frequency and dates of medical evaluations. It must also include notes showing progress or lack of progress, symptoms noted and changes in treatment plans. Ga. Regs. § 290-5-8-.09(3).

[198] "Provisions shall be made for suitable recreational and entertainment activities for patients according to their needs and interests. These activities are an important adjunct to daily living and are to encourage restoration to self-care and resumption of normal activities." Ga. Regs. § 290-5-8.16(2).

[199] Ga. Regs., § 290-5-8-.07(2). Information that must be maintained covers social and emotional factors related to the patient's condition and information concerning his home situation, financial resources and relationships with other people.

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a. Social services must be involved in caring for the resident's psycho-social well-being. Social services ordinarily interacts both with family and with outside consultants, and arranges transportation to those consultants.

These notes should identify family members involved in the resident's care.

18. Dietary records

a. Where there is significant weight loss, dysphasia, or other indication of Altered Nutritional Status, there should be a dietary consult.

b. Dietary services must be qualified to special nutritional needs of geriatric and physically impaired persons; develop therapeutic diets; develop regular diets that meet resident needs. F Tag 361.

19. Consults.[200]

a. Depending on how the facility operates, consultant reports may include inhouse or outside therapy and other services (e.g., psychiatric evaluation) or may include regular therapy such as pharmaceutical services.

20. Treatment Records.

a. Many facilities separately chart specific treatment regimens triggered by RAPs. Among them are wound care, respiratory therapy, etc.

21. Miscellaneous.

Other records that may be mixed in with the records listed above, or that may be separately filed include:

22. Nutrition and vital sign records including weight, intake and output, blood pressure, respiration, heart rate, blood sugar and other vital signs.

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[200] Ga. Regs. § 290-5-8-.11(1)(k).

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23. Medication Administration Records (MARS).[201]

    a. The most recent MARS may be filed separately from the active medical record.[202]

    b. The facility must ensure that residents are free of any significant medication errors. 42 CFR § 483.25(m)(2).

    c. Omitted doses are errors, as well as the reason for the omission or error, should be checked.

24. Weekly decubitus or skin breakdown reports (which may or may not include photographs).

    a. The facility policy and procedure manual should be reviewed to determine whether it requires photographs.

25. Weekly infectious disease reports.

    a. Infection disease reports are prepared pursuant to the facilities infection control policy.

26. Laboratory results.[203]

    a. Blood tests;

    b. Urine tests.

27. Ambulance and EMT Records.

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[201] Ga. Regs. § 290-5-8-.11(1)(h). Each home shall provide pharmaceutical services in full compliance with State and Federal laws and regulation. Ga. Regs., § 290-5-8-.08. All medication must be ordered in writing or oral orders must be reduced to writing and countersigned by the physician. Ga. Regs. § 290-5-8-.10(6). Each dose administered must be recorded in the clinical records. Ga. Regs. § 290-5-8-.10(7). Medication errors must be reported to the physician and an entry must be made on the clinical record as well as on an incident report. Ga. Regs. § 290-5-8-.10(7)(e).

[202] See L. James, Litigating the Nursing Home Malnutrition Case, 1 The Advocate 6 (ATLA Nursing Home Litigation Group 2000).

[203] The facility must provide or obtain laboratory services to meet the needs of its residents. 42 CFR 483.75(j)(1).

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a. Ambulance records may indicate the time an incident occurred, and they should indicate when assistance was requested. They may document the facility's version (one of them anyway) of what happened, and who was involved. They may document the resident's condition and appearance (including hygiene).

28. Nursing Home Discharge Summary.[204]

a. The discharge summary must be signed by the discharging physician, should state the resident's condition at the time of discharge and should recap significant events that occurred during the resident's stay.

29. Death Certificate and Autopsy Report (if applicable).

a. Be mindful of who provided the information in the Death Certificate. You should not take the information on the Death Certificate a "gospel," particularly when the information is provided by the facility. It can, however, provide another source of information concerning what went wrong.

b. Question whether key information is omitted or deleted, either from the Death Certificate or from the Nursing Home record. The Death Certificate may show that someone is covering up the true cause of death.

(B) Other Facility Records That Prove Your Case [205]

[204] Ga. Regs. § 290-5-8-.11(1)(c) (date and time of discharge or death); (e) (final diagnosis) and (f) (condition on discharge).

[205] Adapted from T. Dellacona, Critical Discovery: Getting All The Paper You Need to Win, presented at Nursing Home Litigation: Winning the Case From Start to Finish (Georgia Trial Lawyers Association July 27, 2001); R. Krisztal, Falls and Restraints, presented at Nursing Home Neglect and Abuse Cases Part I (Tennessee Trial Lawyers Association (August 30 & 31, 2002). See also R. Krisztal, Investigation and Pretrial Considerations in the Civil Prosecution of a Nursing Home Case for Personal Injury and Other Damages, in Nursing Home Litigation: Investigation and Case Preparation 361, 365-367 (Lawyers & Judges Publishing Co., Inc. 1999); K. Shapiro, Nursing Home Negligence: Asserting Claims and Defending Nursing Homes, in Nursing Home Negligence Conference II (PESI 2000); and E. Carlson, Litigating Against Long Term Care Facilities § 10.201, in Long Term Care Advocacy (Lexis-Nexis 1999, 2002).

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1. Nursing policies/procedures.[206]

   a. Facility policy and procedure manuals often mirror O.B.R.A. regulations and serve as a separate basis/source for identifying and defining the applicable standard of care. See B. Arbeit, The Administrator and Nursing Home Liability Issues, in Nursing Home Litigation: Investigation and Case Preparation, 111, 114 (Lawyers & Judges Publishing 1999) (hereinafter "Arbeit"). As a persuasion tool, what better source could you find to establish breach than showing that the facility failed to follow its own rules?

   b. Don't overlook the possibility that videotapes may exist which explain internal policies and procedure and how staff members should apply them.[207]

   c. Recurrent violations of the facility's policies and procedures is evidence of an absence of administrative oversight. Selective application of those procedures may be evidence of improper discrimination.

2. Administrative policies/procedures.

   a. Corporate policies may dictate how nurse staffing hours are calculated. If so, this is often done without accounting for acuity data, which may buttress a punitive damage claim for callous disregard to the consequences.

   b. Request an organizational chart, if one exists, so you can clearly explain who reports to whom.

3. Medicare/Medicaid Participation Agreement.

   a. The facility typically executes Medicare/Medicaid Participation Agreement with the State agency responsible for nursing home medicaid. In that agreement, the facility must agree to abide by

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[206] Residents have a statutory right to access the facility's policies and procedures during ordinary business hours. O.C.G.A. § 31-8-106(a)(4).

[207] S. James, Creative Discovery in Nursing Home Cases, 36 Trial 90 (ATLA, July 2000).

OBRA and the underlying regulations.[208] In Georgia the agreement is with the Georgia Department of Community Health. This agreement defines the facilities responsibilities (compliance with O.B.R.A.) And may serve as a source of proof regarding the level of care required.

b. In Brogdon, the plaintiffs argued that they were third party beneficiaries of the participation agreement. Defendants filed a motion to dismiss, which the Court denied. State law governs whether Plaintiff's may sue as third party beneficiaries. Brogdon, at 1334.

4. Photographs of the resident.

a. "A picture is worth a thousand words" and, in nursing home litigation, may be worth hundreds of thousands of dollars. Nursing homes find it virtually impossible to deny photographic evidence of abuse and neglect. Photographs often eliminate controversy concerning the size and severity of pressure ulcers. Typically pressure ulcers are photographed by nursing homes as part of the wound care program and on admission by hospitals as part of their risk management program (e.g., shows that the pressure ulcer did not develop at the hospital). Photographs of inadequate grooming and hygiene eliminate controversy where family state that a resident was left in urine and feces.

b. Secure photographs of the resident before she/he went into the nursing home, while they were in the nursing home and afterward. You will want to show the progression of the resident's health.

5. OSCAR Reports

a. The Online Survey and Certification Reporting System (OSCAR) went online in 1991. See DHHS, Nursing Home Survey and Certification: Deficiency Trends (March, 1999).[209] Facilities submit information on themselves and their residents through OSCAR. "The OSCARs are based on reporting to the state through the MDS forms. Thus, they are only as accurate as the

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[208] This merely restates the regulation. See Ga. Reg. § 290-5-39.07(a) (care must be provided in compliance with all applicable laws and regulations).

[209] http://oig.hhs.gov/oei/reports/oei-02-98-00331.pdf.

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MDS reporting."[210]

b. OSCAR data (which may or may not be compiled at the facility) reflects acuity, providing a way to compare residents with differing levels of independence and differing needs. This data is critical in assessing the sufficiency of staffing.

c. OSCAR data can reflect an absence of care. For example, if the data shows a significantly higher level of incontinence at the facility than the national average, it may be evidence that the facility's bladder/bowel training program is either non-existent or that the facility simply isn't trying on that issue.

d. HCFA Form 672 should be requested. It will document the number of residents who are: bed bound, incontinent, being tube fed, and restrained. This information indicates the acuity level at the facility and is used in conjunction with any staffing analysis.

6. Insurance documents.

a. Examine the applicable insurance documents for representations concerning the facility and for linkages between the facility and related entities.

b. Carefully examine the coverage in policies. For example, if the facility made false representations concerning care, see if there is coverage for false advertising.

7. Contracts between the nursing home and the resident.

a. Who are the contracting parties and what promises were given. What consideration did the facility provide? E.g., sufficient nursing care.

b. Has the facility tried to improperly limit its duties to the resident? At least one home has tried to draft its contract to limit nursing care to 2.0 hours per day. This is inconsistent with OBRA and with State regulations that require "sufficient staffing."

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[210] D. Thomas, Nutritional Deficiencies in Long-Term Care: Part III, http://www.mmhc.com/nhm/articles/NHM9811/Nutdef3.html.

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c. Did the facility secure an illegal third party guarantee?

8. Contracts between the nursing home owner and any management company or other interested parties in the operation of the nursing home.

   a. Who is "really" operating the nursing home and where is the money going? See U.S. News & World Report Special Report, supra. Who is the real defendant? What safeguards are in place to ensure that funds necessary for resident care are reserved?

   b. These contracts may evidence corporate control over management decision making, or may further an argument that one corporation is simply a shell. They may also demonstrate that some "non-profit" companies are really for-profit.

   c. In reviewing the inter-company agreements, determine which entity had the license to operate the facility.

   d. If management has been delegated, what duties did the owner retain, if any? Does the owner have a right to audit the management company?

   e. Get contracts between the facility and anyone else to who responsibility for care was delegated, e.g., the medical director.

9. The patient bill of rights as delivered to the resident.

   a. This is arguably part of the contract with the resident and is certainly proof that the facility "knew" the resident's rights.

   b. This document must be delivered to every resident or his/her responsible party during the admission process.

10. Nursing aid training manuals and booklets.

   a. What should the nursing staff have known and done in treating your client?

   b. Where there is an in-house training program, inadequate CNA training programs may indicate negligent training.

11. Incident reports.[211]

a. In Chandler, supra, records *referring to* incident reports were requested where Plaintiff sought documents that would evidence notice that a Wanderguard system was defective. Plaintiffs cited Peacock v. HCPIII Eastman, Inc., 497 S.E.2d 253 (1998) in support of their motion to compel.

b. In 1620 Health Partners, L.C. v. Fluitt, 830 So2d 935 (Fla. App. 4 Dist. 2002), the Defendant challenged discovery of incident reports asserting work product and other statutory privileges. The Court held that an in camera inspection must take place to determine whether the documents sought were discoverable.

c. In Beverly Enterprises-Florida, Inc. v. Ives, 2002 WL 31487165 (Fla. App. 5 Dist 2002), the Appeals Court quashed an order permitting discover of internal investigation documents on the ground that they included self-critical analysis and, thus, were protected as medical review committee/peer review documents.

d. If incident reports are referred to in medical records, then they become medical records and are subject to the same discovery rules that apply to medical records.

e. Incident reports may reflect corrective action, or a lack thereof; may show when administration had knowledge of an event and, if that date is late or if involvement is insufficient, may demonstrate an absence of administrative oversight.

f. Incident reports are required by regulation, are a routine part of the nursing home's record keeping practice and are discoverable as business records. Virtually all policy and procedure manuals require them (and insurance companies may insist on them) as part of the facility's quality improvement program and as a tool in taking corrective action. Objections that they were prepared in anticipation of litigation are improper.

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[211] Tennessee regulations require maintenance of many of the documents listed in this section if the facility utilizes a secure unit. See Tn. Regs. § 1200-8-11-.05(9). In Peacock v. HCP III Eastman, Inc., 230 Ga. App. 726 (1998), a plaintiff was entitled to *other* incident and accident reports covering an 26 month period since they were relevant in considering his punitive damages claim. They would be relevant to show notice to the nursing home and its staff and that it was not properly supervising residents and that residents were finding their way out.

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g. Incident reports may identify witnesses and participants, may indicate the level of investigation undertaken by the facility and may provide an account of events that conflicts with the medical record.

12. Personnel files of all employees that participated in the resident's care, including termination letters and resignation letters.[212]

13. Copies of any contracts between the facility (or chain) and agencies who provided personnel to perform nursing services.

    a. These contracts are a critical part of the staffing analysis, as are the invoices showing how many agency nursing hours were provided.

14. Billing records.

    a. These records may help show how much the facility takes in each month that could be used for resident care. They may also prove improper billing or outright fraud.

    b. 42 CFR § 483.10(c)(8)(i) provides that a facility "may not charge a resident for" services that are covered under Medicare or Medicaid. Billing records may show improper conduct.

15. Staffing sheets, time cards, payroll stubs with employee signatures.

    a. These records are an essential part of the staffing analysis. They show, not who was suppose to be present, but who showed up for work.

    b. Compare these records to the chart to determine whether the persons charting were really working. If not, they may be evidence of charting fraud.

16. Closed chart audit sheet.

    a. Typically this is a checklist form. Closed record audit sheets should have a statement of what records exist. Missing records are

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[212] The nursing home must maintain a separate file on each employee which includes the employee's application and qualifications, physical exam and identification of job title. Ga. Regs. § 290-5-8-.03(4). The job description can be kept in a separate file. The home must require a physical examination upon employment. Ga. Regs. § 290-5-8-.15.

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a red flag that should be explored.

b. Surveyor guidelines on closed record reviews appear in Survey Procedures for Long Term Care Facilities, Investigation Protocol Nursing Services, Sufficient Staff, at P-53. The scope of the review Surveyor teams should be able to undertake also provides guidance concerning what constitutes a complete record.

17. Patient/Family Grievance Committee Meeting Notes.

a. Council notes may show prior complaints, notice of conditions, and system-wide failure to provide appropriate care.

18. Job Descriptions.

a. Administrator
b. Director of Nursing
c. Charge Nurse
d. Staff Nurse
e. Wound Care Nurse
f. Registered Nurse
g. Licensed Practical Nurse
h. Certified Nursing Assistant
i. Auxiliary personnel

j. Job descriptions will often state specific duties to be performed, chains of command and other information useful in identifying who is responsible for what.

k. Job descriptions may be evidence that one or more staff members are not meeting responsibilities outlined in their job description. Recurrent failure demonstrates an absence of administrative oversight.

19. Twenty-four hour reports, Logbooks, report books, communications notebooks, journals, diaries.

a. These reports, regardless of the name employed, will contain additional information about the resident that is not in the resident's nursing home chart. Ostensibly, the purpose of this record is to communicate from shift to shift. Nursing care is a continuous process so if these records do not exist in some form, this is an issue for exploration in deposition.

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b. These books may include a separate account of any incident occurring on the floor.

c. A different set of books that may be similarly named are sign-in sheets logging visitors (or staff) in and out. These can be critical in showing who was present.

d. Log books may document all incidents within the facility and, as such, may serve as an incident report "index."

20. Documents and Orders from State Licensing Boards.

a. Determine whether members of the caregiving staff providing care to your client are properly licensed and whether any of them have been sanctioned.

21. Business file (and all "other" files) of the resident.

a. Often non-medical documents, such as grievances, are found in a business file.

22. Copies of outside consultant reports.

a. These include (CYA) reports made by the medical director, dietary consultants, and the pharmacist.

23. Other lawsuits against the facility.

a. If the same facility (or corporation) has had the same complaint before and has taken no corrective action, this may be evidence to support a punitive damages claim.

24. Notices to family regarding plan conferences.

25. Hand Books and Treatises.

a. Often there will be reference materials at or near the nursing station. Determine what references the facility considers authoritative and whether the staff deviated from standards in those materials.

26. In-service education or training class information including attendance

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sheets, roster or personnel present and all material presented.

a. Care must be provided by qualified persons. 42 C.F.R. § 483.20(k)(3)(ii). The CMS training requirements and competency standards for nurse aides are found at 42 CFR § 483.150 to § 158. Since a deficient training program is likely to produce substandard CNAs, and because the training materials may serve as an additional source for proving how care should have been delivered, these materials should be secured. See also 42 U.S.C. § 1396r(b)(5) (required training of nursing aides).

b. Among other matters, the CNA curriculum must include training concerning assistance with ADLs, communication, infection control, skin care, recognizing abnormal changes in body functions and the importance of reporting changes to a supervisor, assistance with eating and hydration, proper feeding techniques, transfers, positioning and turning, bowel and bladder training, and resident's rights. 42 C.F.R. § 483.152(b).

c. An active in-service nursing education program shall be in effect and records must be kept showing attendance and progress for each person. Ga. Regs. § 290-5-8-.04(9) and (10).

27. Compilation of charges submitted for resident by the nursing home to Medicare/Medicaid.

a. Beyond billing fraud issues (if you choose to explore them) you will need to know what liens are out there.

b. On Medicaid Liens, see C. Kruse, Third-Party and Self-Created Trusts: Planning for the Elderly and Disabled Client, Third Edition, 175-181 (ABA 2002).

28. Records from the State regarding investigation of complaints, surveys, deficiencies, plan of corrections, ownership disclosure (including amendments), notices of intent to prohibit new admissions, copies of evidence of payment of any fines.[213]

a. The top ten deficiencies reported in 2001 were failure to ensure sanitary food service, failure to ensure quality of care, accidents,

[213] 42 U.S.C. § 1396r(g)(5).

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failure to meet professional standards in conducting assessments; failure to prevent accidents; failure to properly develop comprehensive care plans; dignity rights violationsl failure to prevent and/or treat pressure ulcers; housekeeping issues; infection control issues. See C. Harrington, Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1995 Through 2001 82 (August 2002).

29. Resident's Will, powers of attorney, guardianship and/or estate documentation showing power to act on behalf of the client.[214].

30. Publically available information relating to the nursing home on the internet, SEC disclosure and advertising and promotional materials.

    a. Marketing materials often disclose information concerning nursing home ownership, certification, licensing, size, and other matters. They may include photographs of the facility. Often they promise a level of care beyond what was delivered. See Arbeit, p. 113.

    b. These documents may evidence consumer fraud.

    c. See freeedgar.com

31. The nursing home's actual budget while the resident was at the facility, including breakdowns showing how much of gross revenue was spent on resident nutrition and nursing services.

32. Records of any applicable studies performed at the nursing home.

33. Documentation concerning control asserted on the local facility by regional or national offices of nursing home chains. This should include all correspondence, memoranda or written materials between the facility and corporate offices regarding quality of care, staffing levels, budgets, finances and acuity.

34. Information concerning how local management is compensated.

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[214] Beyond showing entitlement to secure records, these documents may be important as backup for your fee contract.

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35. Acuity reports and statistics at the facility.[215]

36. Mortality statistics at the facility

37. Cost reports submitted to the State and to CMS.

    a. The Annual Cost Report submitted to CMS should identify which part or parts of the facility participate in the Medicaid program, as well as nursing labor costs.

    b. "This issue of distinct parts [of the nursing home] may arise when there are allegations that the quality of care deteriorated [after] a resident [relocates within the facility and the quality of care declines]." Arbeit, p. 117.

    c. States must make cost reports available to the public. 42 U.S.C. § 1396r(g)(5).

38. A copy of the document retention policy.

39. Copies of any and all records from the medical director regarding quality of care provided to residents at the nursing home.

40. Police reports (if applicable).

41. Copies of any statements made by the resident or their caregivers concerning care at the nursing home.

42. Diagram of the facility, showing various stations and rooms.

    a. Facility diagrams and photographs are useful in giving the jury a mental fix on the location where the injury occurred.[216]

    b. They are also useful to an expert doing a staffing analysis. "A large number of private rooms, few ward rooms, and/or long hall

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[215] This information is compiled from the MDS for all residents. During the survey process, the data is compiled for the surveyors' use. See HCFA Form 672. Each home shall keep patient statistics, including admissions, discharges, deaths, patient days, and percent of occupancy. Statistical records shall be open for inspection .... Ga. Regs. § 290-5-8-.11(2).

[216] Associating facts with geography adds to credibility. There is a reason why newscasters stand in the rain on the White House lawn when they tell you what the President did today.

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distances from the furthest resident to the nursing station, the physical plant design mandates a greater need for staffing hours." Arbeit, Selected Strategies Toward Analysis of Nursing Department Staffing in a Nursing Home, at B-5, in Mealey's Nursing Home Litigation Conference 2002 (Lexis-Nexis, January 28-29, 2002).

c. The nurses station shall not be more than 120 feet from the most remote room served. Ga. Regs. § 290-5-8-.18(11).

43. List of names and addresses for current and former care staff.

(C) Damages Evidence

In addition to medical records and facility records, you will need evidence necessary to humanize the nursing home resident and demonstrating the value of the relationship between the resident and his or her family. In a recent case we mediated, we developed a power point presentation showing family photos, family records (birth and marriage certificates), retirement photos, a hymn written by the resident and similar information. You will get most of this information from friends and family members, which may take time. Ask early and, if necessary, ask often and repeatedly. The following checklist may be helpful, but explore the specifics of what made life enjoyable for your client and his family, keeping in mind that every life is unique::

1. Retirement photographs.
2. Wedding and graduation photos of the resident and the resident's children.
3. Photographs from holiday gatherings.
4. Photographs from family albums.
5. Videos of special events or memories.

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6. Letters of commendation, awards, diplomas, certificates.

7. Documents showing military service.

8. Photographs and documents relating to church, employment, social and recreation activity.

9. Information concerning the resident's dreams or goals.

Conclusion

Many of us, as Elder advocates, are actively engaged in helping our clients finance long term care. As such, we are helping our clients open the nursing home door. We cannot stop there. We must go the next step and insist on quality care once our clients take up residence there. At present, the nursing home industry operates amidst a culture of indifference. We must change that culture – insist on accountability. There is simply no excuse for abuse and neglect.

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Appendix A
Nursing Home Statutes & Regulations

State	NH Statutes	NH Regulations
Alabama		
Alaska		
Arkansas		
Arizona		
California		
Colorado		
Connecticut		
Delaware		
DC		
Florida		
Georgia	O.C.G.A. § 31-8-101 et seq.	Reg. 290-5-8-.01 et seq.
Hawaii		
Idaho		
Illinois		
Indiana		
Iowa		
Kansas		
Kentucky	K.R.S. Ch. 216 (Facilities) K.R.S. Ch. 216A (Administrators) K.R.S. Ch. 216B (Regulation of Facilities)	K.A.R. Title 901, 906, 907 and 910
Louisiana		
Maine		
Maryland		

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Massachusetts		105 CMR 150.000 - 159.000 940 CMR 4.00 - 4.11 245 CMR 1.00 - 2.18
Michigan		
Minnesota		
Mississippi		
Missouri		
Montana		
Nebraska		
Nevada		
New Hampshire		
New Jersey		
New Mexico		
New York		
North Carolina		
North Dakota		
Ohio	O.R.C. Chapter 3721	OAC Ch. 3701-17 (NH) OAC Ch. 3701-18 (Training) OAC Ch. 3701-61 (Rights) OAC Ch. 3701-64 (Abuse)
Oklahoma	63 O.S. 1-1901 et seq.	
Oregon		
Pennsylvania		
Rhode Island		
South Carolina		
South Dakota		
Tennessee	T.C.A. § 68-11-901 to 68-11-910	

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Utah		
Vermont		
Virginia		
Washington		
West Virginia	W.Va. Code 16-5C-1 et seq (Nursing Homes); 30-25-1 (Administrators); 16-5L-1 (Ombudsmen); 55-7B-1 (Medical Professional Liability Act)	64 C.S.R. 13
Wisconsin		
Wyoming		

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Appendix B
State Survey Agency Directory

State	State Survey Agency Name & Address	Contact Numbers
Alabama	Division of Licensure and Certification Alabama Department of Public Health PO Box 303017 Montgomery, Alabama 36130-3017	Phone (334) 206-5281 Fax (334) 206-5088 Contact: Pat Ivey
Alaska	Medical Assistance Health Facilities Licensing and Certification 4730 Business Park Boulevard, Suite 18, Bldg H Anchorage, Alaska 99503-7137	Phone (907) 561-8081 Fax (907) 561-3011 Contact: Shelbert Larsen
Arizona	Assurance/Licensure, Health/Child Care Rev Svcs Arizona Department of Health Services 1647 East Morten Avenue, Suite 220 Phoenix, Arizona 85020	Phone (602) 674-4200 Fax (602) 861-0645 Contact: Lourdis Ochoa
Arkansas	Health Facilities Services Arkansas Department of Health Freeway Medical Twr, 5800 W 10th Street, Ste 400 Little Rock, Arkansas 72204	Phone (501) 661-2201 Fax (501) 661-2165 Contact: Renee Mallory
	Office of Long Term Care, Medical Services Arkansas Department of Human Services PO Box 8059, Slot #402 Little Rock, Arkansas 72203-8059	Phone (501) 682-8486 Fax (501) 682-6171 Contact: Carol Shockley
California	Health Services PO Box 942732, 1800 3rd Street, Suite 210 Sacramento, California 94234-7320	Phone (916) 445-3054 Fax (916) 445-6979 Contact: Benda Klutz
Colorado	Health Facilities Division, Building A, 2nd Floor Colorado Dept of Public Health & Environment 4300 Cherry Creek Drive, South Denver, Colorado 80222-1530	Phone (303) 692-2819 Fax (303) 782-4883 Contact: Ellen Mangeoma
Connecticut	Department of Public Health 410 Capitol Avenue, MS#12HSR Hartford, Connecticut 06134-0308	Phone (860) 509-7400 Fax (860) 509-7543 Cynthia Denne
Delaware	Office of Health Facilities Licensing and Certification 2055 Limestone Road, Suite 200 Wilmington, Delaware 19808	Phone (302) 995-8521 Fax (302) 577-6672 Contact: Robert Smith
District of Columbia	Service Facility Regulation Administration Department of Consumer and Regulatory Affairs 825 N. Capital Street P.O. Box 37200, Room 1007 Washington, DC 20002	Phone (202) 442-4747 Fax (202) 442-9430 Contact: Geraldine Sykes

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Florida	Agency for Health Administration 2727 Mahan Drive, Room 200 Tallahassee, Florida 32308-5403	Phone (888) 419-3456 Fax (850) 487-6240 Contact: Pete J. Buigas
Georgia	Office of Regulatory Services Georgia Department of Human Resources 2 Peachtree Street NW, 21 st Floor, Suite 32-415 Atlanta, Georgia 30303-3167	Phone (404) 657-5700 Fax (404) 657-5708 Contact: Martin Rotter
Hawaii	Hospital and Medical Facilities Branch Hawaii State Department of Health P.O. Box 3378 Honolulu, Hawaii 96801-3378	Phone (808) 586-4080 Fax (808) 586-4745 Contact: Diane Okumure
Idaho	Bureau of Facility Standards, Division of Medicaid Idaho Department of Health and Welfare 450 West State Street, 3rd Floor Boise, Idaho 83720-0036	Phone (208) 334-1864 Fax (208) 332-1888 Contact: Loreha Todd
	Laboratory Improvement Section, Division of Health Idaho Department of Health and Welfare 2220 Old Penitentiary Road Boise, Idaho 83712-8299	Phone (208) 334-2235 x245 Fax (208) 334-2382 Contact: David Eisentrager
Illinois	Office of Health Care Regulation Illinois Department of Public Health 525 West Jefferson Street, 5th Floor Springfield, Illinois 62761	Phone (217) 782-2913 Fax (217) 524-6292 Contact: Kelly Cunningham
Indiana	Health Care Regulatory Services Commission Indiana State Department of Health 2 North Meridian Street, Section 3B Indianapolis, Indiana 46204	Phone (317) 233-7022 Fax (317) 233-7053 Contact: Steve Upchurch
Iowa	Health Facilities Division Iowa Department of Inspections and Appeals 3rd Floor, Lucas State Office Building Des Moines, Iowa 50319-0083	Phone (515) 281-4233 Fax (515) 242-5022 Contact: Marvin Tuman
Kansas	Health and Environment 900 SW Jackson, Suite 1001, Landon State Ofc Bldg Topika, Kansas 66612-1290	Phone (913) 296-1240 Fax (913) 296-1266 Contact: Joseph Kroll
Kentucky	Division of Licensing and Regulation Kentucky Cabinet for Human Resources 275 East Main Street, 5E-A Frankfort, Kentucky 40621-0001	Phone (502) 564-2800 Fax (502) 562-6546 Contact: Rebecca Cecil
Louisiana	Health Standards Section Louisiana Department of Health and Hospitals PO Box 3767 Baton Rouge, Louisiana 70821-3767	Phone (225) 342-0415 Fax (225) 342-5292 Contact: Lily McAlister
Maine	Division of Licensing and Certification Maine Department of Human Services - BMS	Phone (207) 287-9300 Fax (207) 624-5378

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	442 Civic Center Drive State House Station #11, 35 Anthony Avenue Augusta, Maine 04333	Contact: Louis Doroqi
Maryland	Office of Licensing and Certification Programs Maryland Department of Health and Mental Hygiene 55 Wade Ave. Baltimore, Maryland 21228	Phone (410) 402-8001 Fax (410) 402-8215 Contact: Carol Benner
Massachusetts	Division of Health Care Quality Massachusetts Department of Public Health 10 West Street, 5th Floor Boston, Massachusetts 02111	Phone (617) 753-8100 Fax (617) 753-8125 Contact: Paul Dreyer
Michigan	Michigan Department of Consumer & Industry Svcs Bureau of Health Systems Division of Health Facility Licensing & Certification PO Box 30664 G. Mennen Williams Bldg, 525 W Ottawa, 5th Floor Lansing, Michigan 48909	Phone (517) 241-2626 Fax (517) 241-2629 Contact: Gladys Thomas
Minnesota	Facility and Provider Compliance Division Minnesota Department of Health PO Box 64900 St Paul, Minnesota 55164-0900	Phone (651) 215-8715 Fax (651) 215-8710 Contact: Linda Sutherland
Mississippi	Health Facilities Licensure and Certification Mississippi State Department of Health 570 East Woodrow Wilson Blvd. PO Box 1700 Jackson, Mississippi 39215-1700	Phone (601) 576-7300 Fax (601) 354-7230 Contact: Vanessa Phipps
Missouri	Bureau of Hospital Licensing and Certification Missouri Department of Health PO Box 570 Jefferson City, Missouri 65102-0570	Phone (573) 751-6302 Fax (573) 526-3621 Contact: Mrs. Jackson
	Institutional Services, Division of Aging Missouri Department of Social Services PO Box 1337 Jefferson City, Missouri 65102-1337	Phone (573) 751-3082 Fax (573) 751-8687 Contact: Bill Toenies
Montana	Quality Assurance, Certification Bureau Montana Department of Health and Human Services PO Box 202953 Helena, Montana 59620	Phone (406) 444-2037 Fax (406) 444-1742 Contact: Linda Sandman
Nebraska	Health Facility Licensure and Inspection Nebraska Department of Health PO Box 94986 Lincoln, Nebraska 68509-4986	Phone (402) 471-0179 Fax (402) 471-3577 Contact: Dept of Health

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Nevada	Bureau of Licensure and Certification/EMS Nevada Department of Human Resources 1550 E College Parkway, Suite 158 Carson City, Nevada 89710	Phone (702) 687-4475 Fax (702) 687-6588 Contact: Richard Panelli
	Bureau of Licensure and Certification/EMS Nevada Department of Human Resources 4220 South Mary Parkway, Suite 810 Las Vegas, Nevada 89119	Phone (702) 486-6815 Fax (702) 486-6520 Contact: Lisa Jones
New Hampshire	Ofc of Prog Support, Licensing & Regulation Svcs Health Facilities Administration New Hampshire Dept of Health & Human Services 129 Pleasant Street Concord, New Hampshire 03301	Phone (603) 271-4592 Fax (603) 271-4968 Contact: Raymond Rusin
New Jersey	Long Term Care Assessment and Survey Division of Long Term Care Systems Development and Quality New Jersey State Department of Health & Senior Services PO 367 Trenton, New Jersey 08625-0367	Phone (609) 633-8980 (609) 984-8118 Fax (609) 633-9060 Contact: Catherine Morris
New Mexico	Bureau of Health Facility Licensing and Certification New Mexico Department of Health 525 Camino de Los Marquez, Suite 2 Santa Fe, New Mexico 87501	Phone (505) 827-4200 Fax (505) 827-4203 Contact: Matthew Gervase
New York	Office of Continuing Care New York State Department of Health 161 Delaware Avenue Delmar, New York 12054	Phone (518) 474-7055 Fax (518) 478-1014 Contact: Cindy Hill
	Health Care Standards and Surveillance New York State Department of Health Hedley Park Place, 433 River Street, Suite 303 Troy, New York 12180	Phone (518) 402-1045 Fax (518) 402-1042 Contact: Sue Ferrau
	New York State Department of Health Office of Managed Care Empire State Plaza, Corning Tower Building Room 2001 Albany, New York 12237	Phone (518) 474-5737 Contact: Kathleen Shure
North Carolina	Certification Section, Division of Facility Services North Carolina Department of Human Resources PO Box 29530 2711 Mail Service Center Raleigh, North Carolina 27699-2711	Phone (919) 733-7461 Fax (919) 733-8274 Contact: Stephen White
North Dakota	Health Resources Section, Div of Health Facilities North Dakota Dept of Health & Consolidated Labs 600 East Boulevard Avenue Bismark, North Dakota 58505-0200	Phone (701) 328-2352 Fax (701) 328-1890 Contact: Cheryl
Ohio	Division of Health Facilities Regulation	Phone (614) 466-7857

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	Ohio Department of Health 246 N. High Street Columbus, Ohio 43215	Fax (614) 644-0208 Contact: Kurt Haas
Oklahoma	Special Health Services - 0237 Oklahoma State Department of Health 1000 N.E. Tenth Street Oklahoma City, Oklahoma 73117-1299	Phone (405) 271-4200 Fax (405) 271-3442 Contact: Commissioner
Oregon	Health Care Licensure and Certification Section Oregon Health Department PO Box 14450 Portland, Oregon 97293-0450	Phone (503) 731-4013 Fax (503) 731-4080 Contact: Jenny
	Client Care Monitoring Unit Senior and Disabled Services Oregon Department of Human Resources 500 Summer Street, 2nd Floor, E-13 Salem, Oregon 97301-1074	Phone (503) 945-6456 Fax (503) 373-7902 Contact: Elaine
Pennsylvania	Bureau of Quality Assurance Pennsylvania Department of Health P.O. Box 90 Harrisburg, Pennsylvania 17108	Phone (717) 787-8015 Fax (717) 787-1491 Dean F. Glick
Puerto Rico	Regulation and Accreditation of Health Facilities Puerto Rico Department of Health Ruiz Soler Former Hospital Bayamon, Puerto Rico 00959	Phone (809) 781-1066 Fax (809) 782-6540
Rhode Island	Division of Facilities Regulation Rhode Island Department of Health 3 Capitol Hill Providence, Rhode Island 02908-5097	Phone (401) 222-2566 Fax (401) 222-3999 Contact: Facility Regulations
South Carolina	Bureau of Certification SC Department of Health & Environmental Control 2600 Bull Street Columbia, South Carolina 29201-1708	Phone (803) 896-0000 Fax (803) 737-7292 Contact: Karen Price
South Dakota	Office of Health Care Facilities Licensure and Certification Health Systems Development and Regulation South Dakota Department of Health 615 East 4th Street Pierre, South Dakota 57501-1700	Phone (605) 773-3356 Fax (605) 773-6667 Contact: Joan Bachman
Tennessee	Division of Health Care Facilities Tennessee Department of Health Cordell Hull Building, 1st Floor 425 5th Avenue North Nashville, Tennessee 37247-0530	Phone (615) 741-7221 Fax (615) 741-7051 Contact: Anna

Texas	Health Facility Compliance Division Texas Department of Health 1100 West 49th Street Austin, Texas 78756	Phone (512) 834-6752 Fax (512) 834-6653
	Long Term Care - Regulatory Texas Department of Human Services 701 West 51st Street, P.O. Box 149030 Austin, Texas 78751	Phone (512) 834-6696 Fax (512) 834-6756 Contact: Jim Lehrman
Utah	Medicare/Medicaid Prgm Cert/Resident Assessment Division of Health Systems Improvement PO Box 144103 Salt Lake City, Utah 84114-4103	Phone (801) 538-6559 Fax (801) 538-6163 Contact: Allan Elkins
Vermont	Division of Licensing and Protection Vermont Department of Aging and Disabilities 103 South Main Street Waterbury, Vermont 05671-2306	Phone (802) 241-2345 Fax (802) 241-2358 Contact: Laine Lucenti
Virginia	Office of Health Facilities Regulation Virginia Department of Health 3600 West Broad Street, Suite 216 Richmond, Virginia 23230	Phone (804) 367-2102 Fax (804) 367-2149 Contact: Nancy Hofheimer
Washington	Facilities and Services Licensing PO Box 47852 Olympia, Washington 98504-7852	Phone (206) 705-6655 Fax (206) 705-6654 Contact: Kathy Stout
	Residential Care Services Washington Department of Social & Health Services PO Box 45600 Olympia, Washington 98504-5600	Phone (360) 493-2560 Fax (360) 438-7903 Contact: Patricia Lashway
West Virginia	Office of Health Facility Licensure and Certification West Virginia Dept of Health and Human Resources 350 Capital Street, Room 206 Charleston, Vest Virginia 25301-3718	Phone (304) 558-0050 Fax (304) 558-2515 Contact: John Wilkinson
Wisconsin	Bureau of Quality Assurance Wisconsin Dept of Health and Family Services PO Box 309 Madison, Wisconsin 53701-0309	Phone (608) 266-2055 Fax (608) 267-0352 Contact: Jan Eakins
Wyoming	Health Facilities Program Wyoming Department of Health First Bank Building, 8th Floor Cheyenne, Wyoming 82001	Phone (307) 777-7121 Fax (307) 777-5970 Contact: Jane Taylor

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